Welcome

As you are aware we endeavour to provide information to AGIP members regarding development in the arena of GI physiology. We also attempt to provide articles which are current, relevant and interesting! We have two excellent articles in this edition which I hope you enjoy reading. However, I would appreciate submissions of articles, letters etc as this is of vital importance in order to keep NewWave current, relevant and interesting!

In addition, advertising by suppliers and manufacturers is also imperative as this goes towards granting bursaries for AGIP members to attend meetings. Therefore, please feel free to pass on my details to any company representative (pharmaceutical or medical equipment supplier) you may meet. If it helps you could show them recent NewWave publications which are on the BSG website. Regards, Warren

warren.jackson@hey.nhs.uk

Difficult upper GI diagnostic challenges insights from new technologies

Yutien Wang, Etsuro Yazaki and Daniel Sifrim
Barts and The London School of Medicine and Dentistry, Queen Mary University of London, UK

Recent developments in new investigational tools have enabled further assessment of patients with functional gastrointestinal disorders which has led to new insights in diagnosis and management.

Dysphagia

The recent development of the high resolution oesophageal manometry (HRM) has enhanced our ability to study oesophageal motility in much greater detail by providing pressure measurements at more levels along the oesophagus. The increase in the number of readings has also led to the use of color contour plots which allow a more intuitive representation of the measured pressure pattern. The development of the Chicago Classification Criteria of Esophageal Motility Disorders, based on HRM, has significantly improved the diagnosis and management of patients with
motility related oesophageal symptoms.

The Chicago Classification is based on analysis of ten 5-mls water swallows. However many patient with oesophageal symptoms have normal HRM findings and do not experience symptoms with these small volume water swallows. The use of complementary provocative tests which includes the use of multiple rapid swallows and solid swallows has been shown to increase sensitivity of detecting motility disorders.

Multiple rapid swallow (MRS) (Figure 1) examines the integrity of inhibitory and excitatory mechanisms which regulate oesophageal motility and esophageal muscle integrity. This is achieved by demonstrating absence of oesophageal smooth muscle contractions during the swallows and the ability to mount a strong after-contraction at the end of the MRS. It is performed by five swallows of 3-mls water each (in 2-3 second intervals) which is directly injected into the patient’s mouth. This test was shown to demonstrate abnormality in 67% of patients with oesophageal symptoms and normal manometry on single water swallows. The ability of patients with oesophageal hypomotility to mount a normal after-MRS response also demonstrates intact muscular integrity which may predict response to cholinergic prokinetic treatment. A recent study also showed that abnormal MRS can predict post-operative dysphagia in patients undergoing anti-reflux surgery.

Solid swallows are performed using 1cm³ bread swallows and normative values have been established previously. In clinical practice, solid swallows are difficult to analyze because it generates complex pressure patterns and the food boluses are often not transported in one single swallow. However, HRM abnormalities detected during the investigation which triggers the patient’s presenting complaint would provide direct pathophysiological diagnoses for their symptoms.

**Post-surgical assessments**

Fundoplication alters the configuration of the distal high pressure zone (DHPZ). HRM is useful for evaluation of post-fundoplication patients with recurrence of GERD symptoms or development of new upper gastrointestinal symptoms by analyzing the strength of the DHPZ and relative positions of the LES and the fundoplication wrap. The various configurations of the DHPZ with corresponding positions of the LES and the fundoplication wrap were recently described. In summary, an elevated single DHPZ at the LES correlates with an intact and appropriately-positioned fundoplication when there is normal pressure and relaxation. An elevated single DHPZ at the LES with low pressure and normal relaxation suggests disrupted fundoplication while with high pressure and incomplete relaxation, it suggests a twisted fundoplication. The presence of a dual DHPZ indicates an inappropriate position of fundoplication (Figures 2a and b).

**Rumination syndrome**

Rumination syndrome is a functional disorder characterized by recurrent regurgitation of ingested food back into the mouth. The diagnosis is based on Rome III criteria. Using combined HRM-impedance monitoring, the diagnosis is supported by identifying raised intragastric pressure generated by voluntary abdominal contractions (absence of retching), which in turn produces retrograde movement of gastric contents through the oesophagus. (Figure 3)

Endolumenal Functional Lumen Imaging Probe (EndoFLIP; Crospon Medical Devices, Galway, Ireland) enables measurement of distensibility of hollow organs. The management of achalasia involves mechanical disruption of LES muscle fibers by surgical myotomy or pneumatic dilatation. While successful treatment can be demonstrated on HRM by the loss of the DHPZ, some patients with low or absent LES pressures remain symptomatic. It has recently been shown
that found that measuring the distensability of the oesophagogastric junction (EGJ) using Endoflip determines oesophageal emptying more accurately that LES pressure 16.

**Refractory GORD**

Approximately a third of patients with suspected gastroesophageal reflux disease are resistant or partial responders to proton pump inhibitors (PPIs). In addition to endoscopy evaluation, the use of multichannel intraluminal impedance-pH monitoring (MII-pH) may identify mixed acid, weakly acidic, bile or gas reflux; impaired oesophageal mucosal integrity or hypersensitivity to refluxates which was not possible with simple pH monitoring 17.

Aetiology of refractory GORD may be classified in the following way

1. Non-erosive reflux disease: patients without any mucosal break at endoscopy and abnormal oesophageal acid exposure at 24-h oesophageal pH monitoring.

2. Acid hypersensitive oesophagus: patients without any mucosal break at endoscopy, normal oesophageal acid exposure and positive symptom-reflux association analysis (symptom index >50%, symptom association probability >95%).

3. Functional heartburn: patients with heartburn refractory to PPIs, without any mucosal break at endoscopy, normal oesophageal acid exposure and negative symptom reflux association analysis (symptom index <50%, symptom association probability <95%) at

**Small Bowel Manometry and transit.**

Small bowel manometry (SBM) gives us useful information of neuromuscular integration by evaluating migrating motor complex (MMC) or other pressure patterns. SBM can be performed on patients with suspected intestinal neuromuscular disorders, such as chronic idiopathic intestinal pseudo-obstruction, pan-enteric slow transit constipation or severe irritable bowel syndrome. Fig 4 shows normal MMC phase IIIs. In the case of enteric neuropathy, MMC phase IIIs can be simultaneous and/or high-amplitude irregular contractions (bursts) can be seen. Also, there are no changes in motility patterns in the post-prandial and/or nocturnal periods.

Small bowel motility in man has traditionally been assessed by measuring intraluminal pressure changes. Intestinal flow or transport of intraluminal contents can be monitored by multi-channel intra-luminal impedance (MII) measurements. However, little is known about the relationships between contractile activity and transport of intra-luminal contents in the human small intestine. Recently we have performed combined SBM and MII technique on patients with suspected intestinal neuromuscular disorders (Fig 5). Preliminary results suggested the combined technique increased diagnostic yields.

SBM is not widely available in UK. This is due to technical difficulties in intubation under fluoroscopic or endoscopic control. Also, there are lack of expertise to interpret data into clinical practice.

Assessment of small intestinal transit is usually performed by radio-opaque markers or scintigraphy. Recently an ingestible, telemetric wireless motility capsule (SmartPill Corporation, Buffalo, USA) enables measurement of regional GI transit times, pH and contractility 18 (Figure 6). Sharp rise in pH is a sign of the entry into the duodenum, and a small drop in pH is usually indentifies entry into the caecum. GI transit times measured by the WMC have previously been shown to correlate strongly with that of other established methods of investigations (9, 10, 16-18) The advantage of the SmartPill is that is a non-invasive technique which involves no irradiation and gives us extra information such as approximate motility. The disadvantage is that it measures a transit of non-
digestible foreign objects rather than food.

References:
Figure 1: HRM of multiple rapid swallows

Figure 2a: Pre-fundoplication HRM showing hypotensive LES and hiatus hernia. The white dashed line shows a hypotensive lower esophageal sphincter. The black dashed line shows the diaphragmatic crura.
Figure 2b: Post-fundoplication HRM showing dual high pressure zones suggesting a slipped fundoplication wrap. The white dashed line shows lower esophageal sphincter. The red dashed line shows the fundoplication wrap.

Figure 3: Combined HRM-impedance monitoring demonstrating rumination. White arrows show raised intragastric pressure. Red arrows show retrograde movement of liquid.
Fig 5. Example of simultaneous recordings of pressure and impedance

Figure 6 Determination of landmarks and regional transit times on plot data obtained from WMC:

Blue line: temperature
White Line: pH
Red Line: Pressure
White arrows indicating respective points of capsule locations
CI: Capsule Ingestion
Py: Pylorus transit
ICJ ileocaecal junction transit
CE capsule expulsion
GET: Gastric emptying time
SBTT: Small bowel transit time
CTT: Colonic transit time
Sandhill Scientific Clinical Training

Synmed hosted another successful CPD Accredited training seminar for GI Motility at the Charing Cross Hotel, London, between 2nd-5th October 2012.

The Seminars were designed for clinicians who are currently performing diagnostic tests in upper and lower GI Manometry and both adult and paediatric reflux testing. It also offered new users the opportunity to acquire the necessary skills to perform these tests in the future.

“Professionally organised course provided by highly experienced practitioners – informative and helpful discussions with interactive case studies and hands-on format. It was very interesting, practical and useful for GI lab practice.”
Dr. Sean Nugent, Whitfield Clinic, Rep. of Ireland.

“A very useful Seminar, which made me think more deeply about every aspect of manometric study in order to improve how the procedures are carried out.”
Ms. Maggie Hastings, Wythenshawe Hospital.

“This training will be invaluable for me to put into practice.”
Ms. Samantha Leach, Cheltenham General Hospital.

We are looking forward to hosting the next Sandhill Clinical Training Seminar in London, in March 2013. (Details will appear shortly on our website: www.synmed.co.uk)

In addition to our advertised courses, we can also deliver bespoke training packages in for groups of up to 4 people. For further information please contact Eleni Kyriacou - Business Coordinator, Synmed - Eleni.Kyriacou@synmed.co.uk
Ardmore healthcare hosted its first ‘Oesophageal Physiology Study Day’ at Hexham hospital on Friday 5th October 2012. The organising committee comprised of Prof Stephen Atwood and Dr Christopher Haigh. The day was well attended by gastroenterologists, physicians, surgeons, respiratory physicians, ENT surgeons, nurses and GI clinical physiologists.

**Organising committee and speakers:**

(Left to right) Dr Christopher Haigh, Dr Jacky Smith, Prof Stephen Atwood Dr Jo Barlow and Prof André Smout

**Prof Stephen Attwood** introduced the day gave an excellent talk on the ‘indications for oesophageal manometry’, highlighting that all patients with dysphagia should have an endoscopy with biopsy to rule out a primary condition of ‘eosinophilic oesophagitis’:

**Eosinophilic Oesophagitis:**

- Primary condition, usually not related to reflux
- Variable endoscopic appearance
I was pleased Prof Attwood reiterated to the audience the importance of oesophageal manometry and 24hour pH +/- impedance studies, highlighting to the audience that an accurate diagnosis is necessary, and that a normal result can by equally important as it can explain why PPI’s are ineffective. Also, if managing post operative symptoms is required you need to know the starting point which can be obtained from oesophageal manometry and 24hour pH +/- impedance studies.

I was also interested in the discussion around tailoring a Nissen fundoplication (360°, 180° etc). Prof Attwood and all of the surgeons present at this study day always perform a 360° wrap. They explain the risks of dysphagia to their patients, which is common early after the operation but usually resolves within 3 months. Late dysphagia (5%) may require a dilatation or rarely (2%) require revisional surgery post fundoplication. Recurrent reflux symptoms can be experienced in 5% of patients but almost always a pH test was negative.

Prof André Smout followed with his presentation ‘how to interpret the clinical diagnosis from HRM’. I have heard Prof Smout talk on a number of occasions and as ever his talk captured the audience. Prof Smout highlighted the well known Ascona Consensus Meeting and how the interpretation of oesophageal motility disorders with HRM follows the new Chicago Classification:

![Classification of esophageal motor disorders](image)

He also commented on the fact that HRM may be easier to perform than standard manometry but interpreting of the results is not! Most of us are aware of the advantages of high resolution manometry over standard manometry and Prof Smout presented a nice slide highlighting that treatment outcomes vary according to the type of achalasia diagnosed with HRM (type I, II or III):
He also presented his algorithms for dysphagia and chest pain:

He also presented his algorithms for dysphagia and chest pain:
Dr Jo Barlow who will be well known to any GI clinical physiologist followed Prof Smout with her talk ‘how to maximise the information gathered during physiology test’ and started off with the basic questions: what do you need to know, what is nice to know and what is superfluous? - essentially what really helps in clinical decision making? Dr Barlow talked about both water perfused and solid state HRM catheters, setting up the equipment, the procedure and common problems encountered. She also concentrated on ‘how to do the analysis’, which I am sure many found useful:

Dr Barlow summarised her talk by saying that although the information gathered using HRM can identify more motility anomalies that standard manometry which ultimately can maximise the potential diagnostic value. Although, it is important to remember the validity of the data is dependent upon accurate catheter positioning and stringent observation of data quality through the procedure as well as careful data analysis and interpretation of the results obtained. I particularly liked Dr Barlow’s final comment which I think can be easily be forgotten; Does the anomaly detected relate to symptoms? and being aware of over interpretation of minor pressure fluctuations.
After a quick coffee break Prof André Smout ran through the interpretation of impedance/pH tracings and gave his algorithms for referred ‘GORD’ patients:

Prof Smout also presented a number of interesting case studies.

Dr Jacky Smith talked about the role of intra and extra-oesophageal reflux, Reflux symptoms in asthma and chronic cough, the association probability for reflux-cough or cough-reflux were elegantly shown:
Dr Smith had presented the evidence of association between GORD and chronic respiratory diseases but concluded by saying that the trials of acid suppression were disappointing, that the mechanisms remain poorly understood and that the role of Non-acid reflux & micro aspiration need further investigation.

Prof Stephen Attwood concluded the morning with his presentation titled ‘therapeutic options for oesophageal physiology dysfunction’ and started with mentioning that the interpretation is both an ‘art and a science’ which John deCaesteker (AGIP president) was credited as using to describe interpreting the results. The science refers to the manometric abnormality and the art refers to what it means i.e. do the symptoms fit, are there transit abnormalities and is it a treatable disorder? Prof Attwood reminded the audience that the result should be taken in a wholistic clinical context and discussed directly with the patient and the whole team should be involved (respiratory physician, ENT surgeon etc).

After lunch an interactive panel session invited questions from the floor and the opportunity to ask the expert panels opinion on the interpretation of any difficult cases that may have been causing concern. The panel also highlighted recent, interesting case studies. Overall the day was not only well organised and chaired, well attended with excellent, distinguished speakers. Plenty of opportunity was given to ask questions and I would urge everyone to attend any future study days that are organised. If you would like to go on a mailing list for any future workshops/study days please email: rachel@ardmorehealthcare.com.
Optimising long term management of Gastro-oesophageal Reflux Disease: Surgery or acid suppression
Stephen Attwood, Consultant Surgeon and Honorary Professor
Northumbria Healthcare and Durham University
Email: Stephen.attwood@nhct.nhs.uk

Introduction
Gastro-oesophageal reflux disease is a chronic disorder which impacts quality of life (HR-QOL) and reduces work productivity. PPIs are now considered as the mainstay of anti-reflux medical therapy. After initial therapy, the main goal of long-term management is to maintain symptom control and return to a normal quality of life. Maintenance treatment with a PPI results in high rates of symptom resolution.

Anti reflux surgery is defined for this discussion as an operative intervention by the combination of repair of hiatus hernia and fundoplication of one kind or another. Laparoscopy has revolutionised the recovery rates from antireflux surgery, and it also facilitates a very high standard of surgery.

Alternative new interventions exist either endoscopically such as stapling or endoscopic suturing, or via laparoscopy such as the magnetic bead device (the Linx) or electrical stimulation of the lower oesophageal sphincter (Endostim).
Reasons to consider antireflux surgery
Anti reflux surgery is suitable for a range of patients and for a variety of reasons. An operation can be considered if a patient is fit to have a general anaesthetic and has a desire to stop their medication or to relieve symptoms not treated by their medication. An operation is suitable when symptoms are poorly controlled despite medication – especially for patients who suffer large volume regurgitation and those who wake at night time with coughing and choking and who have acid tasting fluid or food regurgitated into their throat and airway. Regurgitation into the throat when stooping or exercise can limit patients’ ability to work, play sports or even do simple housework.

A few patients cannot tolerate medical treatment. Acid suppressing drugs are sometimes associated with significant side effects – the commonest of which are diarrhoea, headache, parasthesia and hypomagnasemia. If these limit the quality of life for someone who suffers heartburn then having an operation may allow them to avoid medication and its side effects. For some patients who are well controlled on acid suppression but do not want to stay on pills for the rest of their life an operation is a way of avoiding the need to be on prescription medication in the long term.

The decision on the need for an operation to control reflux symptoms should come from the patient’s desire for symptom control or quality of life issues.

Patients who have persistent symptoms while on a ppi are sometimes described as having Refractory Reflux. Some 10% of patients on full dose ppi still suffer persistent heartburn and even more suffer regurgitation. Some are poorly compliant with timing and/ or frequency of dosing. Others have refractory symptoms different to their initial symptoms with volume reflux and regurgitation while stooping or straining. A third group comprise those whose refractory symptoms are due to an altered sensitivity of perception of a normal amount of acid exposure in the oesophagus, sometimes described as acid hypersensitivity. When this can be confidently measured through 24 hour pH testing with good symptom association (through Symptom probability index, or Symptom Association Probability) this may predict a successful outcome of antireflux surgery. Extra-oesophageal respiratory symptoms of cough (and occasionally asthma) may also be effectively treated by antireflux surgery when the association with reflux can be confirmed.

Before surgery manometry and 24 hour pH test should be performed. One advantage of this is that the patient’s persistent symptoms may be due to other disease. It is essential to confirm reflux before subjecting a patient to an operation and this should avoid the errors in management of achalasia or eosinophilic oesphagitis. Additionally the tests may exclude reflux as the cause of symptoms and direct treatment.

The benefits of surgery
The benefits of antireflux surgery have been the subject of a large European multicentre randomised control trial – the Lotus trial which included > 350 patients randomised to escalating doses of esomeprazole for symptom relief and compared to a standardised laparoscopic Nissen fundoplication, with hiatal repair. The reliability of this in the long term has been identified in the 5 year follow up. This has also shown a better quality of heartburn control, and less regurgitation. The strict follow up protocol highlighted an overall better quality of life after antireflux surgery, although the differences in this study were not marked, because the definition of entry into the study was satisfactory control of acid reflux by ppi. In many patients there is a response to ppi but the symptoms are still present as defined above in the term “refractory reflux”.

Disadvantages of antireflux surgery
Dysphagia early after the operation is common but usually resolves within 3 months. Late dysphagia 5%, may require a dilatation or rarely revisional surgery. Early satiety, weight loss and discomfort with large meals – may be a benefit or a problem. Associated weight loss after a Nissen fundoplication is often reversed after 6 months, but may facilitate improved lifestyle and activity. Hiccough, difficulty burping or vomiting - transient usually but occasionally troublesome. Feelings of trapped wind, bloatedness, and passing increased rectal flatus. This is common but when measured these are common in both medically and surgically treated patients, although more common after surgery.

Recurrence of heartburn and regurgitation – relatively rare but can occur in 10% of patients at 5 – 10 yrs post op. This relatively high rate may be improved by following a standardised procedure such as that achieved by 40 surgeons across Europe who contributed to the LOTUS trial. The quality of surgery is very important when considering an operation and this should be restricted to units with experience and high volume throughput. Revisional surgery may variably needed (2 – 5%) but is often effective when indicated.

Quality assurance in surgery
For patients where surgery is an option, ensure the right surgeon performs a standardised operation for the right indications in the right patient and provides good pre-operative education and testing and post operative support.
When a patient is refractory to medical therapy reconsider the diagnosis of GORD before switching to surgery.

Table 1: Reasons to consider antireflux surgery
- Volume regurgitation despite medication
- Night time choking, coughing and regurgitation, or sleep disturbance
- Inability to perform work, social or housework activities due to regurgitation
- Persistent heartburn despite optimal acid suppressing medication
- Rapid return of symptoms whenever medication is missed
- Side effects from medication limiting their use
- A desire by a young patient to avoid lifelong medical treatments

Table 2: Summary of benefits of antireflux surgery
- Improved quality of heartburn control
- Reduction of regurgitation
- Better sleep pattern
- Increased range of physical activities and exercise
- Avoids the need to remember to take medication
- Psychological effects of not having chronic disease
- The pre-operative work up may identify alternative pathology

Table 3: Summary of Disadvantages of antireflux surgery
- Post operative dysphagia in all for a few months
- Persistent dysphagia in 5% or more
- Need for revisional surgery in 5 – 15%
- Hiccough, early satiety, bloating, increased flatus pr
- Need for general anaesthetic

References:


Forthcoming Events:

We hope to publicise forthcoming meetings and educational events. We would like to invite interested parties to contact the NewWave editor (warren.jackson@hey.nhs.uk) to have their details included in future issues.

Oct – Nov 2012  Medical Measurement Systems (MMS)
web seminars for 2012:
24th Oct 2012  Paediatric Impendence-pH studies
8th Nov 2012  High Resolution Manometry (HRM)
28th Nov 2012  Paediatric High Resolution Manometry (HRM)
Each session has a limited enrolment and is FREE of charge; see their website for further information:

20th - 24th Oct 2012  United European Gastroenterology Week (UEGW)
Amsterdam RAI Convention Centre, Netherlands
Website: www.uegw12.uegf.org

21st Jan 2013  Oesophageal Section Symposium (Royal Collage of Physicians, London) *Reduced registration of £20 for AGIP members*
Call for abstracts / registration form and draft programme contained within this e-newsletter

Abdominal Medicine & Surgery
Colorectal Clinical Nurse Specialist – Pelvic Floor Unit

Grade – Band 7
Salary – £36,552 - £46,374 Inclusive of High Cost Allowance
Hours – Full Time, 37.5 hours per week

Due to increased activity in the Pelvic Floor Unit at GSTT we have are looking to appoint an enthusiastic and motivated Clinical Nurse Specialist. This new post is based in the Pelvic Floor Unit and would suit an experienced nurse who has a continence/colorectal/gastroenterology background or (equivalent experience). The Pelvic Floor Unit is run by an energetic, progressive, multi-disciplinary team, comprising Colorectal Surgeons, Clinical Scientist, Clinical Nurse Specialists and Women’s Health Physiotherapists, all of which are supported by administrative staff. You will work as part of this team to provide a seamless service to patients. The successful applicant will have some management experience, with the ability to work autonomously and as part of a team. All applicants should be able to demonstrate clinical expertise and effective decision-making skills in relation to providing specialist care and support for patients with complex bowel dysfunction. The candidate will also be involved in the co-ordination of patients due to have combined pelvic floor surgery, liaising with surgeons and the patient to ensure that their care is delivered in a timely and organised manner. Within the unit we investigate, diagnose and treat patients with complex bowel dysfunction; including slow-transit constipation and obstructive defecation, faecal incontinence, anal fistulas and fissures and obstetric trauma. The service delivers evidenced-based care that is sensitive to the physical, emotional and psychological needs of patients while maintaining their privacy, respect and dignity. Those candidates that are successful in being short listed will be expected to present to the interview panel a PowerPoint presentation of no longer than 10 minutes (A computer and Screen will be available on the interview day) on the topic question of “What personal/professional qualities and experience can you bring to this role in order to deliver an efficient service”.

For informal discussions about this post please contact: Monica Lyons (Pelvic Floor Unit – Advanced Nurse Practitioner) – Ext: 84191 or Bleep 2794; monica.lyons@gstt.nhs.uk or Mrs Fiona Hibberts (Nurse Consultant – Colorectal) Ext 82568 or Bleep 899423; fiona.hibberts@gstt.nhs.uk

Closing date for advert is 28th October 2012.
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For further information about the Trust, please visit our website at www.guysandstthomas.nhs.uk

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0930 Registration and coffee

1000 - 1230 **BSG Barrett’s guidelines**

**Chair:** Prof Hugh Barr

**Panel:**
John de Caestecker, Nigel Trudgill, Ang Yeng, Stephen Attwood, patient representative

1000 – 1045 Case examples including minimum datasets for reporting (TBA) (10 min)

**Presentation of draft BSG Barrett’s guidelines:**
1. **Diagnosis:**
   - Endoscopic diagnosis (Dr K Ragunath, Nottingham), (10 min)
   - Histopathological diagnosis (Dr S Sanders, Warwick), (10 min)
   - 15 mins discussion

1045 – 1115

2. **Screening and Surveillance:**
   - Screening (Dr R Fitzgerald, Cambridge), (10 mins)
   - Endoscopic Surveillance (Dr M di Pietro, Cambridge), (10 min)
   - 10 mins discussion

1115 – 1200

3. **Management of dysplasia and early cancer:**
   - Indefinite and low grade dysplasia (Dr M O’Donovan and Dr R Fitzgerald), (10 mins)
   - Endoscopic therapy of visible lesions (Prof P Bhandari, Portsmouth), (10 mins)
   - Surgery (Mr S Parsons, Nottingham), (10 mins)
   - 15 mins discussion

1200 – 1230 Critique of BSG guidelines and presentation of German Barrett’s guidelines. Dr Oliver Pech, Weisbaden, Germany.

1230 – 1400 Lunch, poster viewing, industry stands

1400 – 1430 Selected poster presentations (8 x 3 minutes each, 1 slide only); 3 prizes

1430 – 1500 New Chicago classification of oesophageal motility by HRM – what’s new and what’s unclear. Dr R Sweiss, St Thomas’ Hospital, London. 20 mins and 10 mins discussion

1500 – 1530: What does impedance add to HRM and 24 h pH monitoring? How I use this in practice. Dr N Trudgill, Sandwell, Birmingham. 20 mins and 10 mins discussion

1530 – 1600: Can LPR be reliably diagnosed in 2013? Prof Daniel Sifrim, QMUL, London. 20 mins and 10 mins discussion

1600 Close
REGISTRATION FORM

First Name: ____________________________  ____________________________

Family Name: __________________________

Institution: ____________________________

Department: ____________________________

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Dietary Requirements: ____________________________

I enclose a cheque for £50* payable to British Society of Gastroenterology

Please send this completed form and your remittance to:

Dr John de Caestecker
(Oesophageal Section Secretary)

Consultant Gastroenterologist,
Leicester General Hospital,
Gwendolen Road,
Leicester
LE5 4PW

* Reduced registration of £20 for trainee BSG members and AGIP members
BSG OESOPHAGEAL SECTION

Abstract of paper for consideration for poster presentation for Oesophageal Section Meeting
Royal College of Physicians, London, 21st January 2013

Name(s) of Author(s):

Name of Institution:

_____________________________________________________________________________

Title of poster:

_____________________________________________________________________________

**Summary restricted to 200 words:**

8 posters will be selected on the day for 3 minute presentations (1 PowerPoint slide ONLY allowed – please have this ready). Prizes for the 3 best posters!

_____________________________________________________________________________

When completed please return by **Friday December 7th 2012 at the latest** to: Dr J de Caestecker, Secretary, BSG Oesophageal Section [john.decaestecker@uhl-tr.nhs.uk](mailto:john.decaestecker@uhl-tr.nhs.uk)