New Wave

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The Official e-newsletter of the Association of GI Physiology

January 2026

Welcome

Welcome to the **January 2026** edition of NewWave!
If you have any relevant articles or papers that you would like to be included in future editions, please email Gemma Willis

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From the Editor

Hello, and a very happy new year! Welcome to the January 2026 issue of NewWave! I hope you all had a chance to rest and recharge over the festive period and are heading into 2026 feeling refreshed (or at the very least, caffeinated). To begin with, I would like to extend a very warm welcome to Dr Jamal Hayat, who has joined the committee as the new Upper GI Representative. We are delighted to have him on board and look forward to the excellent contributions that he's going to bring.

This issue brings together a great mix of updates, guidance, and reflections from across the GI Physiology community. We start on Page 3 with a roundup of Upcoming Events for 2026, which is perfect for keeping on top of your CPD ready for submissions in April! On Page 4, we introduce AGIP's updated logo; a simple refresh to modernise how we present the organisation across documents, digital platforms and publications, while still keeping everything recognisable and consistent.

On Page 5, we've included AGIP's Position Statement on EndoFLIP. As EndoFLIP continues to be adopted more widely across the UK, this statement sets out AGIP's perspective on its place in practice and the important role GI Physiology teams should have in its oversight, interpretation and reporting.

If you're looking for new career prospects (or know someone who is), Beacon Hospital in Dublin have an exciting opportunity to join their team. All information can be found on Page 6, so do have a look and please share it with your networks.

With every new year, comes a fresh pot of AGIP funding to support members at conference attendance. Details regarding the available bursaries for 2026 can be found on Page 8. These bursaries are a fantastic way to help you present your work and show off your expertise to the wider community, definitely worth considering if you're planning to submit an abstract this year.

On Page 9, you'll find a summary of the AGIP Committee Meeting from December 2025 to keep you in the loop regarding the discussions and workstreams happening behind the scenes! Following on from that, Page 10 includes Guidance for CPD Submission, with some helpful updates to support a smoother and more consistent process over the next few months.

A real highlight of this issue is Page 11, where we're very grateful to share a piece from Silvia Davey, Chair of Achalasia Action. Achalasia Action continue to do brilliant work advocating for patients and improving awareness, around achalasia and it's so valuable to hear that perspective and consider how we can strengthen the diagnostic pathways together. This piece is extremely insightful and I would urge you to take a look.

Finally, on Page 13, we introduce work on standardising GI Physiology reports. This is a big step forward in supporting consistency, clarity, and quality across services, and represents work completed by several members of the AGIP committee. I hope you'll find the documents practical and helpful in day-to-day reporting, and again, please share them with your networks.

As always, I would like to say a huge thank you to everyone who contributed to this issue. If you'd like to get involved in future editions, whether that be through sharing service developments, audits, case studies, conference write-ups, or trainee experiences, lease do get in touch. I'd love to hear from you.

Happy reading!

Gemma Willis

Upcoming Events 2026

January 2026	**UHNM Pelvic Floor Imaging Workshop** 15th—16th January 2026 Stafford UHNM Pelvic Floor Imaging Workshop | The Pelvic Floor Society **26th International Conference on Gastroenterology and Hepatology** 19th—20th January 2026 Vienna Gastroenterology 2026 | January 19-20, 2026 | Vienna, Austria
February 2026	**Endo-anal, Endo-rectal and Pelvic Floor Ultrasound Course** 18th February 2026 Webinar THD
March 2026	**Pelvic Floor and Proctology Course 2026** 2nd—3rd March 2026 London Pelvic Floor and Proctology Course 2026 - St Marks Academic Institute
April 2026	**UKCS 2026 Annual Scientific Meeting** 22nd—24th April 2026 Bradford The United Kingdom Continence Society
May 2026	**Digestive Diseases Week** 2nd—5th May 2026 Chicago, Illinois Home Page - DDW **31st UKCS Annual Scientific Meeting** 8th—9th May 2026 London United Kingdom Continence Society - UKCS 2025
June 2026	**BSG Live'26** 22nd—25th June 2026 **Liverpool** BSG Live'26
October 2026	**United European Gastroenterology (UEG) Week** 17th—20th October 2026 Barcelona UEG

The New AGIP Logo

AGIP has recently updated its logo to give the organisation a more modern and refreshed look. As our work continues to expand, the committee felt he committee felt it was time for a more contemporary look that works consistently across digital platforms, publications, and formal documents.

The updated logo has been designed to be clean, professional, and versatile, ensuring it displays well across everything from NewWave and the AGIP website, to presentations, guidance documents, and social media. Importantly, it also provides a consistent identity that aligns with AGIP's growing national profile .

The design was developed in collaboration with a professional graphic designer, who worked closely with the AGIP Committee to explore several options and refinements. Draft designs were shared with committee members, feedback was incorporated, and the final logo was approved through a committee vote**.**

The new logo will be rolled out gradually across AGIP materials. We hope you like it!

AGIP Position Statement: EndoFLIP

EndoFLIP is increasingly being adopted within UK endoscopy and upper GI services, and its role in the assessment of oesophageal function continues to develop. As use of this technology expands, questions have emerged around professional responsibility, interpretation, and how it fits alongside established GI physiology investigations. In response, AGIP has produced the following position statement to outline its perspective on the appropriate use of EndoFLIP, the role of GI Physiology services, and the importance of clear oversight and contextual interpretation within clinical practice.

EndoFLIP

"FLIP Panometry (EndoFLIP) is an emerging technology that is gradually being introduced into hospitals across the UK. The Association of Gastrointestinal Physiologists (AGIP) believes that GI Physiology departments should play a central role in its development, oversight, interpretation, and reporting.

FLIP measures the distension-induced contractile response, secondary peristalsis, and opening dynamics of the oesophageal body and lower oesophageal sphincter in a sedated patient. This differs from high resolution manometry (HRM), which evaluates primary, swallow-induced peristalsis in a non-sedated, compliant patient. These techniques are not mutually exclusive or interchangeable; rather, they are complementary, offering additional insights into oesophageal dynamics, function, and dysfunction.

Interpretation of FLIP panometry should always be made in the context of the clinical presentation, endoscopic findings, and other complementary investigations (e.g., HRM, timed barium oesophagram). As FLIP continues to evolve, AGIP recommends that GI Physiology units remain integral to its ongoing development, clinical application, and interpretation."

This statement has been prepared on behalf of the AGIP Committee, and approved by Dr Rami Sweis, AGP President.

Employment Opportunity:
Beacon Hospital, Dublin

Beacon Hospital

Job Description

Job Title	**Gastrointestinal Physiologist Chief II (Principle Clinical Scientist)**
Department	**Reflux Service**
Reports to	**Head of Endoscopy and Service Line Development**
Date	**2026**

Overall Purpose of Job

To deliver exceptional, patient-centred care within an environment where quality, respect, caring, and compassion underpin all aspects of service delivery.
The Gastrointestinal Physiologist Chief II is responsible for the investigation, interpretation, and reporting of gastrointestinal physiological function to support the diagnosis and management of motility disorders and functional gastrointestinal diseases. The post holder will be a senior and integral member of the Gastrointestinal team, with responsibility for advanced diagnostic testing, staff training and development, quality assurance, audit, and service development in line with hospital strategy and evolving clinical demand.

Key Responsibilities

Diagnostic Testing

- Perform, interpret, and report specialised gastrointestinal physiology investigations, including but not limited to:
- High-resolution oesophageal manometry
- 24-hour pH and pH-impedance monitoring
- Small Intestinal Bacterial Overgrowth (SIBO) testing:
  Hydrogen and methane breath tests
- Prepare, calibrate, and maintain equipment to ensure accurate and reliable physiological measurements.
- Monitor patients throughout procedures to ensure safety, comfort, and dignity at all times.

Clinical Duties

- Support physicians in the diagnosis and management of gastrointestinal motility disorders (e.g. achalasia, gastroparesis).
- Explain procedures clearly to patients and obtain informed consent in accordance with hospital policy.
- Develop and maintain patient information leaflets to ensure patients are fully informed prior to investigations.
- Analyse diagnostic data and produce comprehensive, high-quality clinical reports.
- Maintain accurate patient records and ensure compliance with data protection and confidentiality regulations.
- Actively contribute to innovation, service improvement, and implementation of best practice guidelines and emerging technologies.

Education, Training, and Leadership

- Provide training, supervision, and mentorship to junior staff, students, and new team members in GI physiology techniques.
- Support ongoing professional development within the department.
- Provide patient education regarding test preparation, procedures, and interpretation of results where appropriate.

Quality Assurance and Service Development

- Participate in audit, quality assurance, and service evaluation activities.
- Contribute to the development and expansion of GI physiology services in line with hospital objectives.
- Demonstrate a proactive approach to risk management, quality control, and continuous improvement.

Skills & Competencies

- In-depth knowledge of gastrointestinal anatomy, physiology, and pathophysiology.
- Advanced technical expertise in motility and pH monitoring systems.
- Strong analytical, interpretative, and problem-solving skills.
- Excellent communication skills to support effective patient interaction and multidisciplinary collaboration.
- High level of accuracy and attention to detail in clinical measurement and reporting.

For further information and to apply, click here.

AGIP Bursaries 2026

The AGIP committee is once again pleased to offer a range of conference bursaries to support members with continuing professional development through national and international conference attendance.

Who can apply?
Accredited AGIP members and STP/ASP trainee AGIP members.

International Bursaries
One bursary will be available from the following options:

Graeme Duthie International Award
Up to £1,500 to attend Digestive Diseases Week (DDW)
2nd – 5th May 2026, Chicago Illinois

European Conference Bursary
Up to £750 to attend a relevant European conference.

Requirements:
- An accepted abstract
  A short conference report for publication in NewWave.

If more than one eligible application is received, the bursary will be awarded by random ballot

National Bursaries (x8 available)

Margaret Marples Bursary
Up to £500 to attend BSG Live '26
22nd –25th June 2026, Liverpool

Requirements:
- A short report on one relevant presentation for NewWave
- Priority given to applicants with an accepted abstract
  Remaining bursaries awarded by random ballot

Application Deadlines

- Graeme Duthie International Award: 22 February 2025
- Margaret Marples Bursary: 14 April 2025
  European Conference Bursary: 26 July 2025

How to Apply
Email the following details to **Joanne Hayes**

- Name
- Organisation
- Bursary applied for
- AGIP membership status
- Job title
- Accepted abstract title (if applicable)

Bursaries will be paid via BACS following submission of appropriate expense receipts and submission of the required report/abstract for NewWave.

AGIP Committee Meeting 8th December 2025

The AGIP Committee met on 8 December 2025 at BSG HQ in London to review ongoing work and identify priorities for the year ahead.

A major update from the Chair confirmed that AGIP is now formally known as the **Association of Gastrointestinal Physiology**, following approval by the BSG. The committee also confirmed that the new AGIP logo has been finalised, with guidance on its use to follow before documents, webpages, and social media are updated.

Significant discussion focused on financial governance and bursary management. As most AGIP finances and expenses are now administered through BSG, the committee explored the implications of this shift, including whether the Honorary Treasurer role remains necessary. While there was recognition of the efficiencies gained, concerns were raised about maintaining AGIP's autonomy and protecting ring-fenced funds. Further discussions will take place with the BSG CEO before any final decisions are made. The committee agreed that existing AGIP bursaries (including the Margaret Marples, European, and Graeme Duthie International Awards) should continue to be honoured.

Progress updates were provided across several operational areas. Work continues on minimum standards and accreditation, including the development of reporting templates (see pages 13-19) and clarification of routes to accreditation for STP and ASP trainees. The committee also agreed to formalise accreditation officer roles, introduce staggered terms to improve succession planning, and move accreditation processes onto an online platform to improve efficiency and accessibility. You can read more about this on page 10.

Updates were also shared on membership criteria, with agreement to remove the one-year post-qualification requirement, recognising that AGIP membership is distinct from accreditation and should remain inclusive. Membership fees will be aligned with BSG policy to reflect different pay bands.

National workforce discussions featured prominently, including updates from CAG on a proposed demand and capacity toolkit for GI Physiology. A sub-group will be established to adapt existing respiratory models for GI services, with opportunities for wider member involvement.

The committee discussed community-based diagnostics, agreeing that while breath testing may be suitable for delivery outside hospital settings, more complex GI physiology investigations should remain hospital-based due to safety and governance considerations. Feedback reflecting this position will be shared with NHS England.

Further updates included overwhelmingly positive feedback from the recent AGIP Masterclass, with discussions around the possibility of hybrid formats to improve accessibility for future events. Ongoing work continues across standards development, paediatric guidance, education and training, and public engagement, including expanding the use of social media to raise awareness of GI Physiology as a profession.

The next AGIP Committee meeting will take place on Monday 9 March 2026.

Guidance for CPD Submission: April 2026

Dr Tanya Miller, AGIP Accreditation Officer
Oxford Universities NHS Foundation Trust

It's that time again, CPD submissions are due by 31st March 2026!

The process has been updated to allow submission of documentation via SurveyMonkey, this link is accessible via the BSG website (under the AGIP, GI Physiology section), the SurveyMonkey link contains all the necessary forms and instructions to enable a complete submission.

Please be aware that this is now the only process for CPD submission and that postal or email documentation submissions to the Accreditation Officer are not accepted.

Online Teams/Zoom meetings are acceptable as external CPD, this includes attendance of webinars, conferences, training courses and distance learning. Please ensure that you include certificates/evidence of attendance for this CPD – programme schedules ARE NOT valid evidence of attendance.

Internal CPD not only includes all statutory and mandatory training but can include internal meetings (either face to face or online). Evidence for meetings is acceptable in the form of a signed letter from the Chair of the meeting who should be able to confirm participation from the register of attendance.

Internal and external CPD can also be the base for reflective practise where appropriate. Six reflective practice accounts spread over 2 years are required (3 per year). Please try to provide a selection of experiences: these may range from case studies, research projects, review of interesting articles/research papers, knowledge gained from attending training/conferences, teaching, processes involved to purchase new equipment etc and discuss (where possible) if these experiences have impacted or changed your service.

N.B. 2025 graduates from the STP programme are NOT required to submit CPD for the 2026 submission. Graduates from 2024 will be required to submit for the year May 2025 to March 2026. Prolonged absences due to sickness, maternity leave are all subject to pro rata submissions. Working from home IS NOT acceptable as exclusion criteria.

Late submissions are subject to an administrative charge of £50 and the portal for submissions will be closed after 31st March 2026

Review of submissions is subject to the availability of the panel. The result of the CPD submission will allow either continuation of membership, OR a request for additional information due to an incomplete submission – a time frame for re-submission will be provided if this is the case.

Failure to submit will lead to removal from the register as an Accredited Independent Healthcare Professional in GI Physiology.

The link to allow electronic submission of CPD via SurveyMonkey, will be disseminated via email in due course.

How GI Physiologists can Help to Improve Achalasia Diagnoses

Silvia Davey, Chair of Achalasia Action

Earlier this year, Achalasia Action launched its first-ever research project into the misdiagnosis and late diagnosis of achalasia in the UK. You can download and read the full report here.

Achalasia is a rare oesophageal motility disorder that causes dysphagia, odynophagia food regurgitation, malnourishment, rapid weight loss, lethargy, and painful chest spasms. Achalasia Action is the only UK-based charity that is solely focused on supporting people with achalasia and their families.

This research was co-produced by patients who have been diagnosed with achalasia and summarises the experience of 350 people living with achalasia within the UK. It revealed alarming patterns and failures, which indicate the extent of the misdiagnosis and delayed diagnosis of achalasia within NHS pathways.

Over half of the respondents endured multiple incorrect diagnoses before receiving an accurate diagnosis of achalasia. Commonly mistaken conditions included acid reflux, anxiety, and eating disorders. More than a quarter (27%) of participants waited longer than three years for an accurate diagnosis, and in some cases, this period stretched for over a decade. Women, in particular, faced disproportionate delays and misdiagnoses, often due to physical symptoms being erroneously attributed to psychological factors. This highlighted a clear gender disparity resulting in further psychological harm to female patients.

The diagnostic journey was notably fragmented, and involved interactions with numerous healthcare professionals, ranging from GPs to specialist practitioners, many of whom lacked sufficient awareness or understanding of achalasia. This fragmented pathway not only delayed diagnosis but also significantly damaged patient trust and satisfaction with the healthcare system, exacerbating feelings of isolation and medical dismissal. Patients frequently noted being misunderstood or dismissed by healthcare providers, intensifying their frustration and sense of helplessness.

Importantly, the study found that only 61% of respondents received oesophageal manometry testing, the gold-standard investigation for achalasia, which provides crucial information to inform appropriate intervention.

The physical and psychological consequences of delayed diagnosis and misdiagnosis were profound, significantly reducing patients' quality of life. Notably, participants detailed a substantial deterioration in their health whilst awaiting diagnosis, describing rapid weight loss, malnutrition, chronic pain, and high rates of anxiety and depression.

This is more than a report; it's a critical call for change. Achalasia Action urges NHS leaders, clinicians, policymakers, and government to act now so achalasia patients finally get the timely diagnoses and compassionate care that they deserve. Four key health system recommendations are proposed...

1) Improving education and training for healthcare professionals on achalasia, prioritising general practice and gastroenterology specialties, whilst tackling gender bias in the interpretation of symptoms.

2) Improving the diagnostic pathways of achalasia by setting out a nationally agreed algorithm for primary care; ensuring increased availability of oesophageal manometry; and developing national guidelines on the diagnosis of achalasia.

3) Implementing supportive communication standards and aftercare plans for people with achalasia.

4) Renewing the UK policy agenda for rare diseases ensuring the timely renewal of the UK Rare Diseases Framework.

Specifically, Achalasia Action urges GI physiologists to implement the following changes to practice:

If a manometry confirms that a patient has achalasia, sensitively provide them with supportive information on achalasia. You can direct them to Achalasia Action's website, helpline (0300 772 7795) and information and support videos and booklets.

As part of MDT conversations, raise the need for multidisciplinary support for newly diagnosed patients, including nutrition and mental health support. People with achalasia are rarely offered this type of multidisciplinary support.

A GI Physiologist's point of view: Andres Vales, Clinical Scientist, The Functional Gut Clinic

For GI physiologists, the satisfaction of seeing a manometry trace indicative of achalasia can be a double-edged sword. Typically, there is relief for the patient that they can finally have an answer, a feeling that is amplified by both the severity of the symptoms and the length of time taken to be diagnosed. This is countered, however, by the knowledge that achalasia is a lifelong condition. Nevertheless, physiologists can have limited awareness of the patient experience both before and after they undergo testing.

The advances over recent years in technology and oesophageal disorder classification have likely led to improved outcomes once the patient undergoes physiology testing. However, it is unclear what effect these advances have had on improving patient access in terms of reducing the time from symptom onset to diagnosis and simplifying referral pathways from primary to tertiary care. By improving appropriate patient access, the work by clinicians to advance physiology can have a bigger impact.

This report by Achalasia Action shines a light on the patient experience with eye opening findings. It also suggests a road map for future improvements and puts down a marker for us to compare them against. The report includes recommendations at the national NHS and Department of Health level which not only seek to improve achalasia diagnosis but are aligned with better support for GI physiology departments. It also includes low hanging fruit improvements which individual physiologists can make.

These suggestions to improve patient support following diagnosis can have a big impact quality of life, as confirmed by current achalasia suffers, and can be the first steps towards wider collaboration with patient advocacy groups.

Standardising GI Physiology Reporting
AGIP Committee Subgroup

High-resolution oesophageal manometry is a core investigation within GI Physiology, yet the way studies are reported has historically varied between centres, measurement systems, and individual practitioners. Differences in report structure, terminology, inclusion of key metrics, and the use of automated software outputs can make interpretation challenging for referrers, complicate multidisciplinary decision-making, and limit comparison between centres. As testing protocols have expanded to include provocative manoeuvres and adjunctive metrics, the need for clarity, consistency, and professional judgement within reporting has become increasingly important.

In response to this, a working group within the AGIP committee has developed a set of standardisation documents to support best practice in HRM reporting. These include guidance on the essential elements of a high-quality report, alongside example templates aligned to different manufacturer platforms. The aim is not to restrict scientific interpretation or replace clinical judgement, but to ensure that all reports contain the key elements that are required to allow clear and meaningful interpretation, regardless of where the study is performed.

These documents emphasise the importance of integrating findings across water swallows, provocative testing, and symptom correlation, rather than relying solely the automated classification. They also reinforce the role of the clinician in providing an additional, structured narrative interpretation, highlighting study quality, limitations, and clinical findings. By encouraging a consistent reporting framework, the committee hopes to support referrers, to strengthen governance and quality assurance within oesophageal physiology.

The guidance and templates published across the next few pages represent the output of collaborative work by members of the AGIP Committee, drawing on expertise from across the specialty. They are intended as practical tools to support day to day clinical practice and will continue to evolve as further scientific evidence, technology, and guidelines develop. Members are encouraged to review and adopt these documents where appropriate within their local services

GUIDANCE

High Resolution Oesophageal Manometry –

Essential Elements of a Report

Target Audience	Professionals certified in the performance of High Resolution Oesophageal Manometry
Document Reference:	AGIP.HROM.1
Version:	1.0
Approved by AGIP Committee Date:	January 2026
Review Date:	January 2029
Frequency of Review:	3 yearly

A well-structured **High Resolution Oesophageal Manometry (HRM)** report should include the following essential elements: **Patient Information**

- Patient's full name, date of birth, NHS or hospital number, the hospital and department details (e.g. location, contact details) where the HRM study was conducted
- Date of investigation and who referred the patient for the HRM study
- Indication for the study (e.g., dysphagia, chest pain, GORD, pre/post fundoplication, POEM etc.)
- Brief clinical history, duration of symptoms, summary of previous investigations (e.g. OGD, barium). Relevant Medication - PPI, H2RA antacids, neuromodulators, prokinetics. nitrates, calcium channel blockers, opiates etc.
- Dysphagia and reflux questionnaires should be included; it is up to the unit to decide which ones they prefer. For example for reflux 'The Reflux Disease Questionnaire' (RDQ), for atypical symptoms 'The Reflux Symptom Index' (RSI) /
- 'The Hull Airway Reflux Questionnaire' (HARQ), for dysphagia 'Eckardt score' or Dysphagia Symptom Questionnaire (DSQ), for quality of life 'GERD Health'

Related Quality of Life Questionnaire' (GERD-HRQL) and for anxiety the 'Hospital Anxiety and Depression Questionnaire (HADS).
Include patient's height, weight and state the patient's BMI

Technical Details
Patient position during the study for each measurement taken e.g. upright, supine or both. The swallow protocol must include 10×5 mL water swallows and at least one form of provocation. Provocative testing may include any/combination of 2 x Multiple Rapid Swallows (MRS 5×2mL), Rapid Drink Challenge (RDC 200mL drunk freely), Solid Test Swallows (e.g. at least 5 x cubes of bread) or Solid Test Meal (e.g. bowl of rice or a sandwich).

For postprandial testing (e.g. for conditions such as Rumination), a postprandial protocol can be performed such that after a culprit food/drink is provided during manometry, the test is prolonged for 10-15 minutes to observe for postprandial effects.

Throughout the study, any symptoms that occur should be recorded directly onto the trace to allow correlation with any observed preceding dysmotility

Study Quality
Please report:

- Any technical limitations (e.g. catheter dislodgement, sensor issues, artifact etc.)
- Replication of patient symptoms/symptom correlation (notation of any symptoms experienced during the test and if they correlate with manometric findings such as dysphagia, Rumination, regurgitation, belching and retch/vomit
- Comment on patient tolerance (e.g. good, poor, frequent swallowing etc.)

Lower Oesophageal Sphincter (LOS) Assessment
Mean resting pressure (taken over 20-30 seconds of no swallowing) - specify patient position. If the patient is unable to tolerate this duration, a minimum of 3 respiratory cycles may be used as a last resort.
Median Integrated relaxation pressure (IRP4) - key metric for LOS relaxation; specify patient position*
Distance of the proximal border of the LOS from nares (essential for accurate pH/ impedance probe placement)
Presence or absence of hiatus hernia (state length in cm if there is a hiatus hernia)

**Please note: An elevated IRP should be interpreted in the context of an underlying primary motility disorder, prior surgical or endoscopic intervention, or anatomic variation that may affect the measurement. Assessment of the presence or absence of oesophagogastric junction outflow obstruction (OGJOO) should be guided by the results of provocative tests (e.g., RDC, MRS, upright water swallows, STS or STM).*

Comment if the LOS pressure is normal, hypo- or hypertensive
Esophagogastric Junction Contractile Integral (EGI-CI) is an optional metric on HRM reports

Oesophageal Body Motility

- Peristaltic integrity: normal, ineffective (inc. weak, failed, premature or fragmented contractions) commenting on the percentage of each. Comment on any change or peristaltic recovery that may occur during provocative testing.
- Distal contractile integral (DCI): should be reported as mean and ideally include an individual breakdown of swallows (e.g. table of the 10x5mL water swallows)
- Distal latency (DL): should be reported as not just the mean but ideally include an individual breakdown of swallows (e.g. in a table of the 10x5mL water swallows)
- Presence of breaks in the peristaltic contour (i.e. large/small breaks)

continued...

- Intrabolus pressure pattern e.g. normal, EGJ, compartmentalised, panesophageal pressurisation (if software allows)
- Pan-oesophageal pressurisation (POP) should be measured at an isobaric contour of 30mmHg and the frequency that this occurs with water swallows and provocative manoeuvres should be described

Additional Information

- MRS - comment on the peristaltic reserve and the post MRS DCI
- RDC - comments on LOS relaxation (RDC-IRP-30)
- Other provocative testing (e.g. single solids, test meal) - comment on the DCI, IRP, DL and any relevant symptom association to allow correlation with any observed dysmotility
- Impedance - comment on the % of impaired bolus clearance if associated with any ineffective swallows, if relevant .

The report should include representative images of relevant swallows, highlighting any abnormalities identified during the HRM study from water or provocative tests
Do not include the morphed (superimposed) images potentially available in the HRM software which is normally generated from water swallows as this may be misleading. If one is required, a tiled image of the 10x5mL water swallows is preferred to provide an overview (see page 1 of the 'AGIP example HRM report' as an example)

Oesophageal Manometry Summary

A comprehensive diagnosis should be provided based on the entire study. It is important to note that the automated (software generated) HRM Chicago Classification is generated by all approved boxed swallows. It is simplistic and does not include nuanced interpretation. Analysis should be undertaken separately for every water swallow position (boxing only swallows that are being analysed for each run through). The software is not set up to analyse provocative testing so this should not be boxed and analysed by the automated software. Rather interpretation of the provocative tests should be undertaken manually.

1. MRS: post MRS swallows should be analysed on their own (primarily for DCI, peristaltic reserve and POP).
2. RDC: The RDC-IRP should be analysed by dragging the IRP box across the entire free drinking period. Presence of POP should be mentioned.
3. Solid swallows should be analysed and interpreted manually, primarily looking for pathology (hypercontraction, raised IRP, POP and unusual patterns such has pressurisation and shortening) or confirming peristaltic reserve.

Therefore, the HRM investigator must integrate the results from all manoeuvres (both water swallows and provocative tests) to determine the most appropriate Chicago classification, in accordance with the latest version of the classification (currently Version 4).
Recommendations, if appropriate (e.g., further testing such as a standard or timed barium swallow, EndoFLIP etc.)

Maximum Reporting Time

• The investigator should aim to finalise and return the HRM report along with the 24-hour pH/impedance study report (where applicable) to the referring consultant within two weeks of the investigation date.

Performance of High-Resolution Oesophageal Manometry in Adults and Paediatrics

Target Audience	Professionals certified in the performance of High Resolution Oesophageal Manometry
Document Reference:	AGIP.HROM.2
Version:	2.0
Approved by AGIP Committee Date:	January 2026
Review Date:	January 2029
Frequency of Review:	3 yearly

AGIP Guidance for the performance of High Resolution Oesophageal Manometry

The member of staff performing the procedure must be either fully trained and accredited by AGIP in this procedure or supervised by a fully trained and accredited practitioner.

HRM is a dynamic evaluation of oesophageal function, making it essential that practitioners understand the nuances of all metrics informing a Chicago Classification outcome. Experienced practitioners may deviate from conventional procedures, reflecting the assessment's adaptive nature, which may not always produce a strict, formal Chicago Classification diagnosis.

Patient Selection and Preparation in Advance of Procedure:

- Unless contraindicated, patients should always undergo an endoscopy with appropriate oesophageal biopsies (within 2 years) prior to referral for oesophageal physiology studies, especially when presenting with symptoms of dysphagia, regurgitation or chest pain. This allows for the assessment of any disorders that could account for patient symptoms; malignancy, structural abnormalities (e.g. stricture, oesophageal diverticulum, pharyngeal pouch or varices) and mucosal pathology with biopsies (e.g. eosinophilic oesophagitis, candida).
- Patients referred for cough or throat symptoms, who do not have heartburn, acid regurgitation, chest pain or dysphagia, do not necessarily require endoscopy as long as no additional symptoms develop. They may instead require direct visualisation, e.g. with laryngoscopy.
- Fluoroscopy with video recording (e.g. barium swallow) reported by an experienced GI radiologist can provide complementary information and might also detect abnormalities not appreciated by endoscopy, but mucosal disease cannot be excluded.
- Patients should be informed of the date of their tests well in advance, to allow for any relevant medication known to affect oesophageal motor function (e.g., nitrates, calcium channel blockers, opiates, anticholinergic drugs and prokinetics) and anti-secretory medications (should pH monitoring be planned at the same appointment) to be stopped (as per local SOP and in line with BSG guidelines). Opiates and certain other medications cannot always be terminated unless they have been newly commenced. In some cases, if they have been taken for prolonged periods, they might be the causative agent. Therefore, tests may be performed whilst on certain medications to assess the cause of presenting symptoms. Whether to perform the test on or off opiate medication should be determined as per local protocol and in agreement with clinical leads.
- Patients should fast for 4 hours prior to the test (water is acceptable up until 2 hours prior). If achalasia is suspected, a more prolonged fast is advisable. However, in certain circumstances, fasting may be waived, particularly if the test is being performed to target the post-prandial period.

Patient Preparation on Attendance:

AGIP recommend a Local Safety Standards for Invasive Procedures (LocSSIP)) be developed detailing the actions required for the procedure to ensure safe care for patients undergoing the procedure.

- Check patient details prior to starting the procedure as per local policy.
- Take a history from the patient. Assess and document any relevant symptoms, confirm and document that all relevant medications (if necessary) have been stopped and document other ongoing medicines.
- Explain in detail the procedure to the patient to allow full co-operation during the test.
- Patients must be given an opportunity to allow any questions or concerns be answered to their satisfaction before the procedure begins.
- Informed patient consent (in accordance with local policy) must be obtained prior to the start of the procedure.
- If local anaesthesia is to be used, this must be given in line with local policy.

Equipment Preparation:

The AGIP committee recommends using a solid-state HRM catheter with less than 2 cm sensor spacing preferably with impedance sensors.

- If a reusable solid-state catheter is used, these must be decontaminated prior to first use and after each use, as per local and manufacturer requirements.
- Prepare the room with required consumables prior to testing.
- Verify and zero the catheter in accordance with manufacturer's guidelines.

Performance of the Procedure:

- Staff should wear appropriate personal protective equipment in line with local SOP.
- Explain each step of the procedure to the patient to ensure compliance.
- If local anaesthesia is being used, apply this to the nose and or throat and allow time for it to take effect. Alternatively, anaesthetic gel can be used.
- Apply lubrication gel to the tip of the catheter to improve patient comfort.
- Insert the catheter into the nares and gently advance the catheter through the nasal cavity to the back of the throat (approx. 15cm).
- Ask the patient to tilt their head slightly down towards the chest and to start taking very small continuous sips of water through a straw to help the natural progression of the catheter and reduce retching/vomiting.
- Gradually intubate until the visual display indicates the correct positioning of the catheter; ideally with both the UOS and at least 3 cm beyond the LOS in view. Occasionally this is not possible in tall patients - in which case, visualisation of the UOS sphincter can be sacrificed in favour of positioning the LOS in the correct place with enough sensors in the stomach. If clinically indicated, this could be performed after the standard protocol by withdrawing the catheter several centimetres to visualise the UOS and repeating appropriate measurements.
- Secure the catheter in place with hypoallergenic tape.
- Ask the patient to take 3 deep breaths to visualise diaphragmatic pinch and confirm correct positioning of catheter.
- Document on the trace the depth of the catheter by referring to its markings at the start of recording.

Test Protocol:

- We recommend the protocol outlined in table 1. This is an amendment on the standardised protocol as outlined in the Chicago Classification v4.0[1] and accompanying protocol technical review[2] . We strongly recommend that solid swallows are used for all patients.
- In addition, AGIP recommend the following areas of good practice regarding testing:

- The landmark setting of 20-30 seconds is most representative when the patient is acclimated and calm; although normally defaulted by the software to the beginning, this may be shifted anywhere during the analysis where the LOS is at rest for 30 seconds (i.e. after the initial 10 x water swallows). During this time, the patient should be asked not to hold their breath, rather to breath normally, rhythmically and comfortably without swallowing, belching or speaking. The landmark can be shifted anywhere within the trace during the analysis phase as long as the period of rest is in place. Indeed, it is recommended that a new landmark is used for every position change so a 30second period of rest should be applied at the start of every position change or catheter shift.
- Give the patient 5ml of room temperature water or saline (if the HROM catheter has the addition of impedance) from a syringe and ask the patient to swallow all of it in one go. Ask the patient not to swallow again, talk, cough, retch, move or belch. Wait for 20-30 seconds from the onset of the last swallow before administering the next 5ml bolus.
- It is important that the LOS hypercontraction of the previous swallow does not overlap with the start of the next swallow. Repeat this process to ensure 10 individual swallows are assessed.
- Solid bolus – AGIP recommend bread (with or without butter). Do not use marshmallows for solids, this liquifies. A viscous bolus may not reproduce an equivalent response to a solid bolus.
- Test meal – AGIP recommend a meal such as a 200g bowl of room temperature rice, a sandwich, or a culprit meal brought in by the patient, particularly if symptoms occur whilst eating and symptoms have not been reproduced with all other swallow manoeuvres.

Table 1. The Chicago Classification protocol technical review recommendations for required and optional tests dependant on starting position

HRM Protocol	Test
Primary position 5ml water x10	Required
Alternative position 5ml water x5-10	Optional
Multiple rapid swallow x1-3	Required
Rapid Drink Challenge x1	Required
Single Solid Swallows x10	Required
Solid Test Meal +/- Post prandial observation	Required if rumination suspected
200mL carbonated drink challenge	Required if retrograde cricopharyngeal dysfunction suspected

Post Procedure:

- Extubate the catheter. Ask the patient to blow air through the nose into a tissue, and gently but quickly remove the catheter.
- If a solid-state catheter is used, hold it still for a few seconds, ensuring sensors are not touching anything to allow for thermal compensation (if recommended by the manufacturer).
- Save the recording and disconnect the catheter.
- If using a reusable solid state HRM catheter, this needs to be immediately decontaminated as per local and manufacturer's protocol (e.g. Tristel Trio Wipe system). The relevant details should then be entered into the appropriate cleaning log.
- If a single use water-perfused catheter has been used, then dispose into the appropriately.
- The patient may go home or progress onto a 24-hour pH (+/-impedance) study as required.

Reporting:

- Manual analysis of the recording and subsequent reporting should be in line with the most recent 'Chicago Classification' (currently Version 4.0 and accompanying technical review). It is important to recognise the limitations of the current iteration of the Chicago Classification and to ensure that interpretation takes these limitations into account (e.g. current algorithmic outcomes are based solely on water swallows).
- Published system-specific normal values should always be used; however, emphasis on 'function' rather than simply what falls outside of the normal range is crucial, as well as to recognise that there may be plenty of variation with regard to how to translate the findings.
- Reports should follow the standards outlined in the 'AGIP essential elements of a report' document.
- We recommend that unusual results/ tracings are discussed in an appropriate MDT.

References

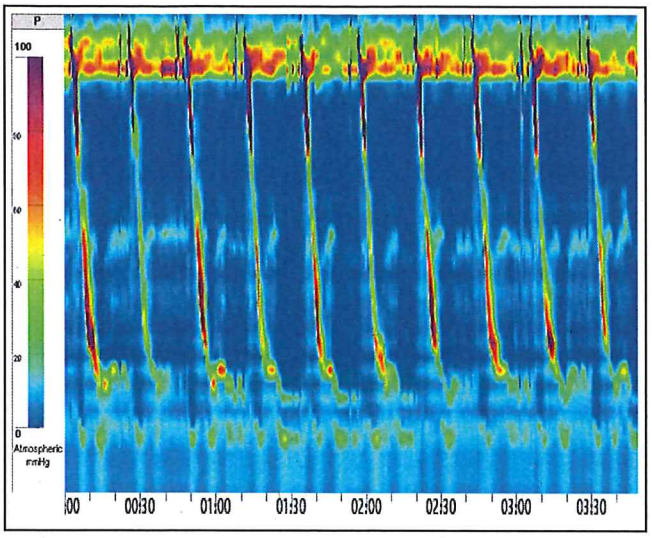
1.Yadlapati R, Kahrilas PJ, Fox MR, Bredenoord AJ, Prakash Gyawali C, Roman S, et al. Esophageal motility disorders on high-resolution manometry: Chicago classification version 4.0©. Neurogastroenterology & Motility 2021;33(1):e14058.

2.Fox MR, Sweis R, Yadlapati R, Pandolfino J, Hani A, Defilippi C, et al. Chicago classification version 4.0© technical review: Update on standard high-resolution manometry protocol for the assessment of esophageal motility. Neurogastroenterology & Motility 2021;33(4):e14120.

Esophageal manometry

Patient name:	AGIP 2025, Template	Investigation date:	11/08/2025
Date of birth:	14/01/1992	Hospital:	Castle Hill (01482 624036)
Patient MRN:	0123456789	Investigator:	Warren Jackson
		Referred by:	

Average of 10: Wet Swallow 5ml - Supine Analysis type: Esophageal



Esophagus

DCI	864 mmHg.s.cm
Peristaltic breaks	0.2 cm
Distal Latency	6.6 s

UES

Upper border	16.7 cm
IRP 0.2 s	9.8 mmHg

LES

Upper border	41.2 cm
Resting pressure (mean)	13.2 mmHg
Median IRP4	6.2 mmHg

Scoring parameter percentages4

Scoring 4	
Normal	90 %
Ineffective	10 %
Failed contraction	0 %
Premature	0 %
Hyper	0 %
Fragmented	0 %

Intrabolus pressure pattern	
Normal	100 %
EGJ	0 %
Compartmentalized	0 %
Panesophageal	0 %
Unknown pressurization	0 %

Average esophagus results

Wet Swallow 5ml - Supine	DCI mmHg.s.cm	Peristaltic breaks cm	Distal Latency s
1	1636	0.0	6.5
2	218	0.0	6.3
3	1248	0.0	6.3
4	532	0.0	6.5
5	902	0.0	6.5
6	492	0.0	6.3
7	1164	0.0	6.5
8	1049	0.0	7.0
9	801	1.1	7.2
10	602	1.3	6.5
Average	864	0.2	6.6

Investigation conclusion

Reason for Referral (Provided by Referrer): Recent OGD = 5cm hiatus hernia and oesophagitis (Grade A). ? suitable for anti-reflux surgery.

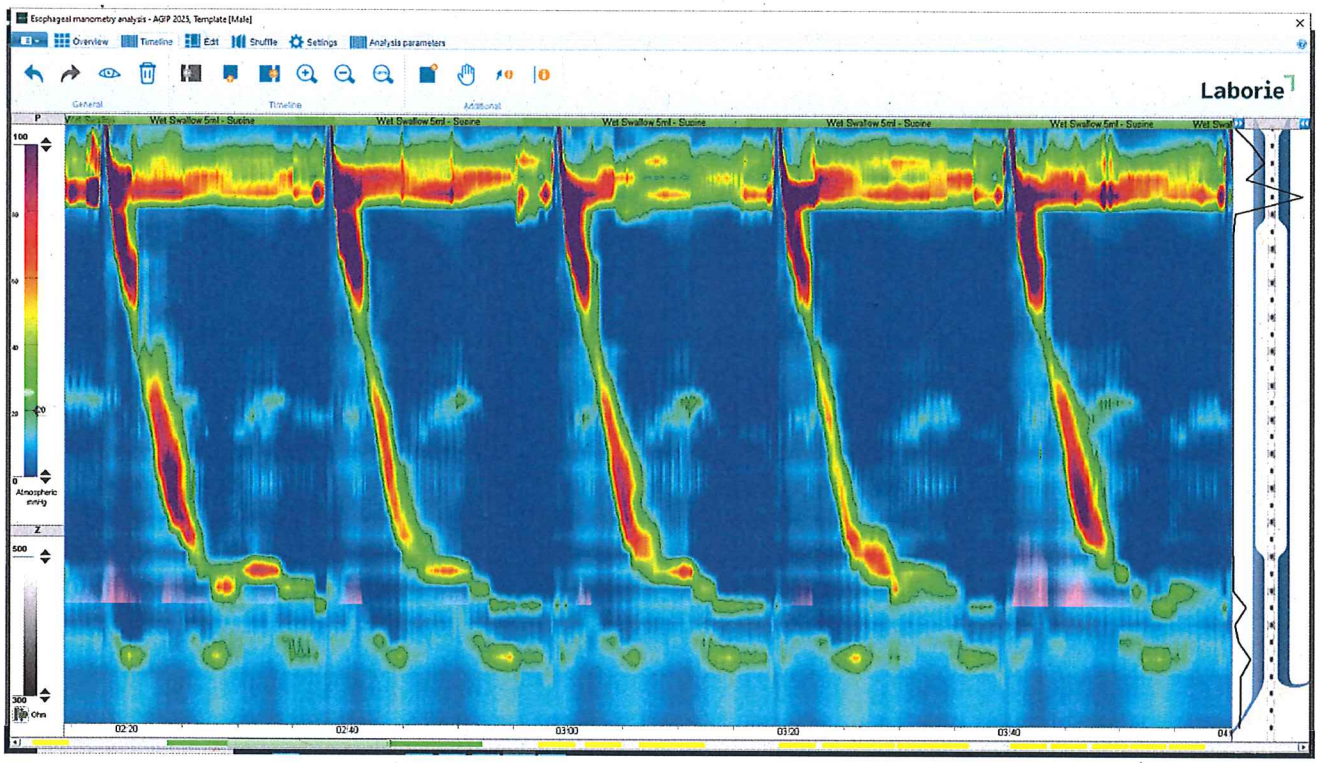
Technical (Clinical Scientist/Investigator's) Report: There were no technical limitations during this study. The patient tolerated the procedure well and no symptoms were reported during the study. However, symptoms are primarily GOR related (5-year duration, PPIs provides only partial relief). Patient is not on any medication that could affect this study.

GERD-HRQL questionnaire: 26/50. Patient's Height: 168cm, Weight: 102kg = BMI 36.4.

Manometric GOJ Morphology: There appeared to be a ~4cm hiatus hernia.

The Oesophagogastric Junction in the supine position: (includes the LOS and the hiatus hernia) resting pressure was 13mmHg, and the median integrated relaxation pressure (IRP) demonstrated adequate relaxation at 6mmHg.

Water (10x5ml) Swallows (WS) in the supine position: 90% were classified as normal and 10% ineffective (weak contraction). There was satisfactory bolus transit when the impedance channels were activated (light purple colour) as complete clearance of the water was observed on 100% of the water swallows:



Multiple Rapid (5x2ml water) Swallows (MRS) in the supine position: Normal inhibition of peristalsis was observed during the multiple rapid swallows and the presence of a post-MRS DCI contraction (2312mmHg•s•cm) was observed.

Solid Test (10xbread) Swallows (STS) in the upright position: Bread swallows met the Chicago Classification criteria for normal. Specifically, 3/10 swallows demonstrated a DCI > 1000mmHg·s·cm, 6 /10 returned a DCI 450-1000mmHg·s·cm, whilst 1 /10 retuned a DCI 100–450 mmHg·s·cm. The Integrated Relaxation Pressure (IRP) was within normal limits, suggesting adequate relaxation.

Oesophageal Manometry Summary: Summary of the full study, to include interpretation and a conclusion in accordance with the most recent Chicago Classification (currently version 4), this should be based on the analysis of the complete study dataset.

Please see the separate report for the 24 hour pH/Impedance study.

IRP Normal upper limit (supine)	22.0 mmHg	Unisensor solid state
IRP Normal upper limit (upright)	15.0 mmHg	Unisensor solid state

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

High-Resolution Oesophageal Motility Study

Northern General Hospital
Dept of GI Physiology
0114 271 4293
Sheffield

Patient:					
AGIP 2025, Template	Gender:	Female	Referred by:		
MRN: 123456789	DOB / Age:	01/02/2003	Operator:	Gianni Raise	
	Height:	170cm	Weight: 60kg	BMI: 20.8	
	Procedure:	Oesophageal HRM	Examination Date:	10/11/2025	

Lower Oesophageal Sphincter Region		Normal
Landmarks		
Proximal LOS (from nares)(cm)	44.3	
LOS length(cm)	3.4	2.7-4.8
Oesophageal length (LOS-UOS centers)(cm)	28.0	
Intraabdominal LOS length(cm)	1.2	
Hiatal hernia?	No	
LOS Pressures		
Pressure meas. method	eSleeve ,IRP	
Basal (respiratory mean)(mmHg)	24.0	13-43
Residual (mean)(mmHg)	9.6	
Residual (median)(mmHg)	9.4	<12.0
Residual (highest)(mmHg)	12.4	
Percent relaxation(%)	68	>40.0%

Upper Oesophageal Sphincter		Normal
Mean basal pressure(mmHg)	49.5	34-104
Mean residual pressure(mmHg)	-1.0	<12.0
Relaxation duration(ms)	708	480-1020

Oesophageal Motility		Normal
Number of swallows evaluated	10	
Chicago Classification		
% failed	0	
% weak	0	
% panesophageal pressurization	0	
% premature contraction	0	
% fragmented	0	
% intact	100	
Number of hypercontractile swallows	0	
Additional High Resolution Parameters		
Distal latency	4.9	
Distal contractile integral(mean)(mmHg-cm-s)	1398.8	450-8000
Distal contractile integral(highest)(mmHg-cm-s)	2026.9	

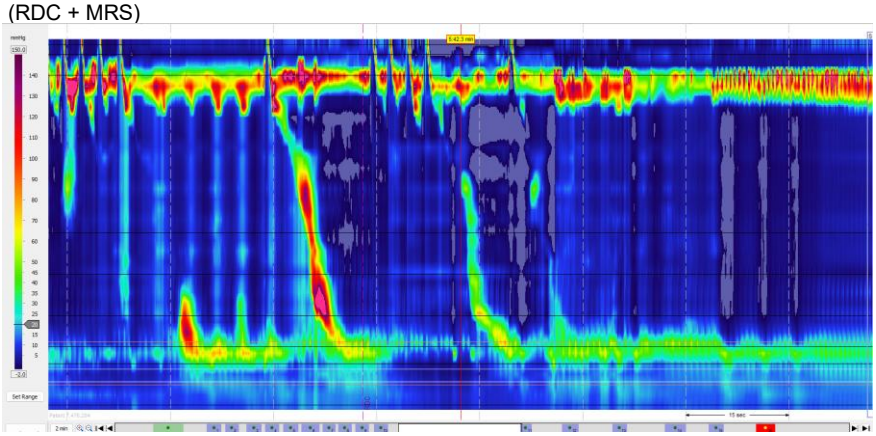
Technical (Clinical Scientist/Investigator's) Report

Reason for Referral (provided by referrer)
Patient presents with a 2-year history of tight chest pain, regurgitation of acid and persistent throat clearing which have all been unresponsive to PPI treatment. They currently take Famotidine.

GERD-HRQL Questionnaire Score=25/50

Study Quality:
Technical Limitations: None
Patient position: Upright
Patient Tolerance: Good
Symptoms: None reported during testing
Medication affecting test: No, famotidine ceased for testing

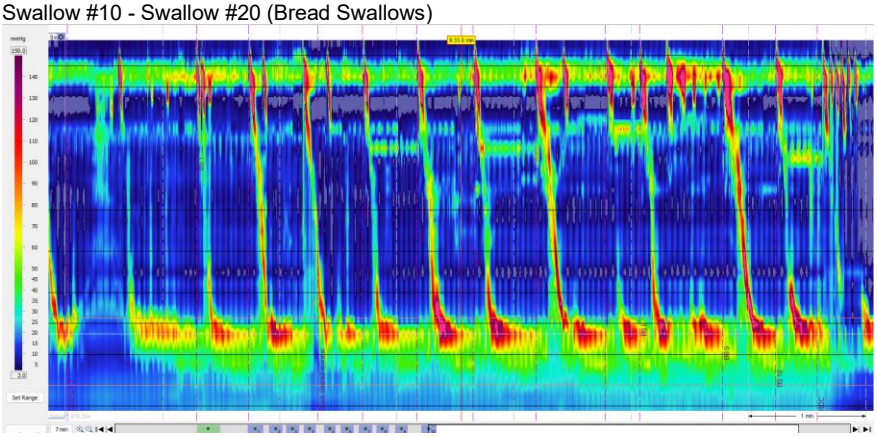
(RDC + MRS)



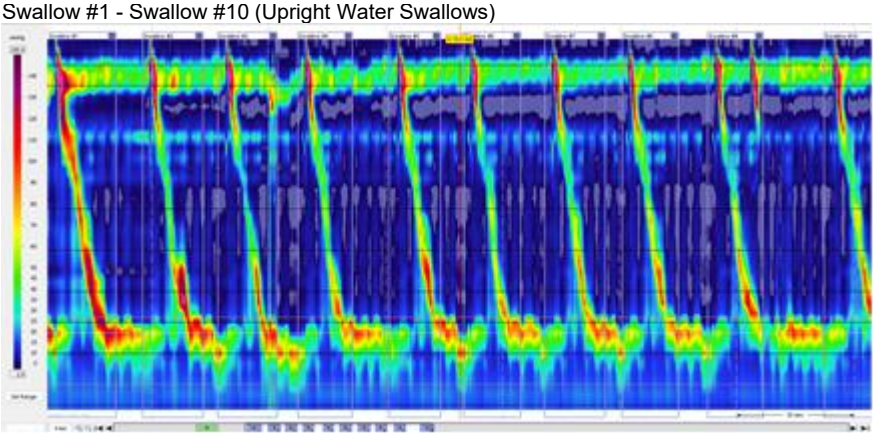
GI EN IMAGING

Northern General Hospital
Dept of GI Physiology
0114 271 4293
Sheffield

Swallow #10 - Swallow #20 (Bread Swallows)



Swallow #1 - Swallow #10 (Upright Water Swallows)



Oesophageal Manometry Summary

Lower Oesophageal Sphincter: Normotensive
Hiatus Hernia: No evidence of a hiatus hernia
LOS Relaxation: Normal

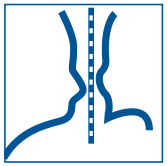
Upper Oesophageal Sphincter Function: Normal
Oesophageal Motility Classification: Normal oesophageal motility

Adjunctive Tests;
RDC: Normal LOS relaxation
MRS: Peristaltic reserve observed
Bread Swallows: Supportive of normal oesophageal motility

Please see additional report for the 24 hour pH/Impedance study

MANOalpHa HIGH RESOLUTION MANOMETRY SYSTEM

SYNMED



MANOalpHa High Resolution Manometry System is designed to better map, measure and evaluate oesophageal motility by providing accurate measurement, adaptive software, and an automated reprocessing solution. It consists of the MANOalpHa central processor, reusable probe, calibration set and the optional portable cart with HD display screen and high-speed printer.

Features:

Automated Reprocessing

- Validated for cleaning and reprocessing using automated reprocessing machines.
- Warranty: 2 years / 200 uses.

Accurate Measurement

- Solid-state sensor with up to 40 pressure sensors and 16 impedance sensors.
- Live acquisition of LOS relaxation.

Easy Operation

- Smaller diameter helps ease patient's discomfort.
- All-in-one workstation, with the whole procedure conducted on one portable cart.

Adaptive ManoLAB Software

ManoLAB software is a versatile tool for editing and navigation of your manometry study. Adapting to the latest Chicago Classification 4.0, ManoLAB provides the clinician with reliable and comprehensive data for an accurate assessment of oesophageal function.

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