AWE-10 AN INTERNATIONAL SURVEY ON THE DIAGNOSIS AND MANAGEMENT OF SEVERE GASTROINTESTINAL DYSMOTILITY

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Introduction Severe gastrointestinal dysmotility (GID) can be sub-classified into Chronic Intestinal Pseudo-obstruction (CIPO) and Enteric Dysmotility (ED) subtypes. We surveyed current opinions on the diagnosis and management of GID amongst experts from different countries.

Methods An survey questionnaire developed by the European society for Clinical Nutrition and Metabolism (ESPEN) was circulated electronically to members of ESPEN, European Society of Neurogastroenterology and Motility, and United European Gastroenterology. Only participants that completed all required components were included in the analysis.

Results Of 154 included participants, 82% were European, the majority were attending clinicians/professors (85%), based at either national/regional referral centres and/or academic institutions (87%). Almost all (93%) agreed that CIPO and ED should be classed separately. Most (73%), reported increased incidence of GID, with 69% reporting an increase in ED. GID associated with hypermobile Ehlers-Danlos Syndrome was the group with the largest increase in referrals (37%), however this trend was driven by observations from UK participants only ($P < 0.0001$). Almost all clinicians (95%) find diagnosing GID difficult, with 57% finding ED more challenging and 32% find both types equally difficult. GID diagnosis is often delayed (CIPO: by >5 years according to 16%; ED: by >5 years according to 19%). Moreover, by the time of diagnosis, >10% of patients have had inappropriate operations according to 82% of clinicians. Small Bowel Manometry, a test mandated to diagnose ED, is surprisingly never used by 44%, and is only used in >50% cases by 21%. Full thickness biopsies are usually requested from planned/previous resections (33%) or when the diagnosis is unclear (43%), but seldom change medical treatment (12%), nutritional management (16%) and prognosis (25%). Very few treatments are useful for >50% of patients, with antibiotics for SIBO, prucalopride, and psychology felt to be the most useful. Parenteral Nutrition (PN) rarely leads to improvement in symptoms (28%), and is associated with PN dependency at 5-years according to the majority (56%).

Conclusion These data highlight the difficulties with diagnosing and managing GID, even in 'expert' hands, and inform the urgent need for international, multidisciplinary, clinical practice guidelines.

Posters

PWE-076 EFFICACY OF PHARMACOLOGICAL THERAPIES IN PATIENTS WITH IRRITABLE BOWEL SYNDROME WITH DIARRHOEA: NETWORK META-ANALYSIS

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Introduction Over half of patients with irritable bowel syndrome have either diarrhoea (IBS-D) or a mixed stool pattern (IBS-M). The relative efficacy of licensed pharmacological therapies in IBS-D and IBS-M is unclear in the absence of head-to-head trials. We conducted a network meta-analysis to resolve this uncertainty.

Methods We searched MEDLINE, EMBASE, EMBASE Classic, the Cochrane central register of controlled trials, and clinicaltrials.gov through November 2018 to identify randomised controlled trials (RCTs) assessing the efficacy of licensed pharmacological therapies in adults with IBS-D or IBS-M. Trials included in the analysis reported a dichotomous assessment of overall response to therapy, and data were pooled using a random effects model. Efficacy and safety of all pharmacological therapies were reported as a pooled relative risk of remaining symptomatic with 95% confidence intervals (CIs) to summarise the effect of each comparison tested. Treatments were ranked according to their P-score.

Results We identified 18 eligible RCTs (7 alosetron, 5 ramosetron, 2 rifaximin, 4 eluxadoline), containing 9844 patients. All were superior to placebo for the treatment of IBS-D or IBS-M at 12 weeks, according to the Food and Drug Administration (FDA)-recommended endpoint for trials in IBS (Figure 1). Alosetron 1mg twice-daily ranked first for efficacy, based on the FDA-recommended composite endpoint of improvement in both abdominal pain and stool consistency (RR = 0.69; 95% CI 0.60 to 0.80, P-score = 0.97), effect on global symptoms of IBS, and effect on stool consistency. Ramosetron 2.5mcg once-daily was ranked first for effect on abdominal pain (RR = 0.75; 95% CI 0.65 to 0.85, P-score = 0.94). Total numbers of adverse events were significantly greater with alosetron 1mg twice-daily and ramosetron 2.5mcg, once-daily, compared with placebo. Rifaximin 550mg three times daily ranked first for safety. Constipation was significantly more common with all drugs, except rifaximin 550mg three times daily.

Conclusions In a network meta-analysis of randomised controlled trials of pharmacological therapies for IBS-D and IBS-M, we found all drugs to be superior to placebo, but alosetron and ramosetron appeared to be the most effective.

Abstract PWE-076 Figure 1. Forest Plot of the Indirect Evidence for Failure to Achieve the FDA-recommended Endpoint to Define Treatment Response.

PWE-077 BIOFEEDBACK: TIME TO LET THE DIETITIAN JOIN THE SERVICE?

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Introduction In 2015 a new dietetic service was established to provide dietary modification including low FODMAP advice for patients as part of the biofeedback service for patients with functional bowel disorders such as faecal incontinence and evacuatory disorders. Studies have reported the effectiveness of diet in IBS^{1,2} but no research has investigated diet in the biofeedback. The aim of this audit was to evaluate the effect on patient outcomes of dietary intervention in this new biofeedback service (BF) and compare it to the established dietetic gastroenterology clinic (GC).

Methods A retrospective audit was undertaken on the effect of personalised dietary advice. At the first appointment patients were asked to complete the gastrointestinal symptom rating scale (GSRS) and answer the question 'do you currently have satisfactory relief of your gut symptoms. These were repeated at each review. Patients were screened and given first line advice or low FODMAP advice or first line advice followed by low FODMAP if first line did not result in satisfactory relief of symptoms. Comparisons were made on effectiveness of dietary intervention in and between the two clinics.

Results A total of 46 patients were included (22GC:24BF). Mean age 54±16years, 8M:38F. Dietary advice provided: first line (22%), low FODMAP (63%), first line and then low FODMAP (15%). Dietetic intervention led to improvements in symptoms in both clinics. More patients in the BF (54%) reported satisfactory relief of their symptoms compared to the dietetic GC (41%). Improvement was evident for all symptoms (Table 1) and is comparable between the two clinics, although improvement in abdominal bloating was notably higher in BF

Abstract PWE-77 Table 1 Difference in% symptom relief between the two services

Symptom	Biofeedback	Gastroenterology
Abdominal Pain	42	62
Bloating	79	62
Flatulence	62	65
Belching	60	39
Abdominal gurgling	56	45

Bowel Urgency	50	50
Incomplete Evacuation	48	65
Nausea	57	60
Heartburn	44	67
Acid Regurgitation	22	73
Tiredness	29	29

Conclusion Our audit highlights the role of a dietitian within a biofeedback multi-disciplinary service and that dietary advice including first line advice and the low FODMAP diet can improve symptoms in patients with faecal incontinence and evacuatory disorders as well as IBS.

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PWE-078 PATIENT EMPOWERMENT IN IRRITABLE BOWEL SYNDROME: DEVELOPMENT OF AN EDUCATIONAL LEAFLET

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Introduction Irritable bowel syndrome (IBS) is a prevalent functional gastrointestinal disorder. Previous studies showed that 'Acceptance' can predict quality of life and illness behaviour [1]. A patient education leaflet (EL) was developed to promote patient education and thus patient acceptance and empowerment.

Methods 30 consecutive patients attending a Specialist Motility clinic at a Tertiary referral centre completed a questionnaire to identify current patients' knowledge on IBS. Patients were asked to suggest what type of information and in what format, they felt was needed. The data was collected and analysed. Based on patients' preferences an EL was developed. EL included definition, symptoms, causes, and management of IBS. EL was then distributed to patients attending clinics and their views on this leaflet were recorded.

Results Only 30% of patients received information regarding their condition prior to attending the Specialist clinic. 60% of patients expressed the need for further education regarding their symptoms and management. 57% of patients preferred information in the form of a leaflet and only 30% requested workshops on IBS or an app in addition to EL. Workshops were suggested as an additional more interactive approach. Patients' preference for EL was to include an extra session on pathophysiology of symptoms. No correlation was noted between the duration of symptoms and patients' knowledge. One patient (4%) did not find that the education provided via EL helped them understand their condition or symptoms (see Figure 1).