BSPGHAN
working for children with digestive and liver disorders

British Society of Paediatric Gastroenterology Hepatology and Nutrition

BSPGHAN Associates and Trainees Meeting

Tues 27th Sept 2016 – Weds 28th Sept 2016

Alder Hey Children's NHS
NHS Foundation Trust

Inspired by Children

BSPGHAN Associates and Trainees Meeting

Tues 27th Sept 2016 – Weds 28th Sept 2016

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BSPGHAN Associates and Trainee Members' Meeting

Tues 27th Sept 2016 – Weds 28th Sept 2016

Welcome to the 2016 BSPGHAN Associates and Trainees Meeting

For Trainees, the meeting is structured over two days. The first day focuses predominantly on issues around training. There will be an opportunity to hear more about the START exam, and we hope that Trainees who have already taken the exam will be able to contribute insights. In the afternoon, Trainees have a choice (numbers permitting) of attending an endoscopy workshop that is based either on basic skills (for new endoscopists) or management of upper GI bleeding, or have a programme of interactive sessions on management relevant to those shortly taking up Consultant posts. The second day is joint with Associate members. Where there are parallel sessions, please do feel free to move between them as you wish. Thank you to those of you who have submitted research abstracts and cases for presentation.

A few messages: Firstly, please try to visit the sponsor stands during the breaks, the meeting is reliant on sponsorship to keep costs low for attendees. Secondly, note that there will be opportunities to meet one-on-one with Sue Protheroe, CSAC Chair, for 10-15 minutes during breaks/lunch etc on the first day of the meeting. Thirdly, Richard Hansen is looking for enthusiastic twitter users to help live-tweet the BSPGHAN annual meeting in 2017 – please have a chat with him or me if you are interested in helping out.

Thanks to the Alder Hey team, especially Christos Tzivinikos, Marcus Auth and Emma Jones; to Nicky Heather, AM Chair; Sandhia Naik, Education Chair; my predecessor Fiona Cameron and Carla Lloyd for all their efforts in helping to organise this meeting.

I hope you enjoy the meeting,

Kelsey Jones
Chair of Trainee Members' Group

Tuesday 27th September 2016

Trainees' day

9.00 – 10.30

Registration

Institute in the Park Reception Area

10.40 – 10.50

Welcome and Introduction

Dr Kelsey Jones
Specialist Registrar
Oxford University Hospital
John Radcliffe Hospital, Oxford OX3 9DU

Chairs:

Dr Kelsey Jones Specialist Registrar Oxford University Hospital John Radcliffe Hospital Oxford	Dr Christos Tzivinkos Consultant Paediatric Gastroenterologist Alder Hey Hospital East Prescot Road Liverpool

10.50 – 11.25 ***CSAC Update: Training, Curriculum, Documentation, Paperwork***

Dr Sue Protheroe
CSAC Chair, Consultant Paediatric Gastroenterologist
Birmingham Children's Hospital
Steelhouse Lane
Birmingham, B4 6NH

11.25 – 12.25 ***START Practice Session***

Dr Sue Protheroe CSAC Chair Consultant Paediatric Gastroenterologist Birmingham Children's Hospital Steelhouse Lane Birmingham	Dr Sandhia Naik BSPGHAN Education Chair Consultant Paediatric Gastroenterologist Training Programme Director Royal London Hospital London
Dr Rajeev Gupta CSAC Advisor Consultant Paediatrician Barnsley Foundation Hospital Gawber Road, Barnsley	Dr Mona Abdel-Hady Liver Training Advisor Consultant Paediatric Hepatologist Liver Unit, Birmingham Children's Hospital, B'ham

Dr Priya Narula
BSPGHAN Endoscopy Working Group Chair
Consultant Paediatric Gastroenterologist
Sheffield Children's Hospital
Western Bank, Sheffield

Dr Richard Hansen
Consultant Paediatric Gastroenterologist
Royal Hospital for Children
1345 Govan Road
Glasgow

12.25 – 12.50 ***Management of Chronic Diarrhoea***

Dr Sarang Tamhne
Consultant Paediatric Gastroenterologist
Alder Hey Hospital
East Prescot Road
Liverpool L14 5AB

12.50 – 14.00

Lunch and opportunity to visit sponsor stands

Transport to Mersey School of Endoscopy
Royal Liverpool University Hospital, Prescot Street, Liverpool
at 13.30 for Endoscopy Training

14.00 – 17.00 (OPTION 1)

Endoscopy Training at
Royal Liverpool Hospital

Group One:	***Group Two:***
Senior Trainees (max 8)	***Junior Trainees (Max 12)***
Mersey School of Endoscopy	***Royal Liverpool Education Centre***
Lecture Theatre	
GI Bleed Stations	Model Work:
Animal Tissue Models	1 Colonoscopy station
	1 Simulator station
	1 Upper GI Station

Trainers:

Mersey School of Endoscopy – Animal Tissue Training:

Dr Neil Haslam and Dr Paul Collins

Education Centre – Model Work:

Nurse Consultant Pauline Reid

Dr Priya Narula
Chair of BSPGHAN Endoscopy Working Group
Sheffield Children's Hospital
Western Bank, Sheffield

Dr Krishnappa Venkatesh
Consultant Paediatric Gastroenterologist
Alder Hey Hospital
East Prescot Road, Liverpool

Dr Richard Hansen
Consultant Paediatric Gastroenterologist
Royal Hospital for Children
Govan Road, Glasgow

Dr Sandhia Naik
BSPGHAN Education Chair
Consultant Paediatric Gastroenterologist
Royal London Hospital, London

Refreshments will be available in the afternoon

14.00 – 17.00 (OPTION 2)

14.00 – 15.30

Management Skills for New Consultants

Mr Dan Grimes
General Manager
Alder Hey Hospital
East Prescot Road, Liverpool L14 5AB

Overview of how the NHS works

1. Tips on business cases
2. Clinical leadership – roles and expectations – round table discussion with scenarios

15.30 – 15.45
Coffee

15.45 – 17.00

Practical Tips on Being a New Consultant
Dr Christos Tzivinikos
Consultant Paediatric Gastroenterologist
Alder Hey Hospital
East Prescot Road, Liverpool

Dr Protima Amon
Consultant Paediatric Gastroenterologist
Barts
London

Tips on how to become a consultant

- Entry requirements, application and interview process

Finding your niche

- Management, special interest, research
- Education and supervision
- Appraisal and GMC requirements
- Survival tips from real life experience as a new consultant

17.00
Transport to Premier Inn
Roby Rd, Liverpool L36 4HD

18.00 – 19.00 ***Trainee AGM***

19.30 – late ***Evening Dinner at Premier Inn***

Wednesday 28th September 2016

BSPGHAN Associate and Trainee Members' (BSPGHAN ATM) Meeting

Institute in the Park, Alder Hey Hospital, Liverpool

Welcome to the Associates day of the ATM meeting!

This day provides us with an opportunity to listen to a variety of topics which hopefully appeal to all our members. It's a 'hot topic' so we decided this year to devote quite a bit of time in exploring the use of blenderised diets. Increasingly we are seeing families who are choosing to tube feed their children in this way and I think we would all like to understand more fully the advantages and disadvantages of using these diets. It is a topic relevant to Dietitians but also to Nurses as they have to manage the care of tubes. Whereas there is plenty of anecdotal evidence on the benefits of the blenderised diet we are very excited about the research that is being done in Glasgow into their use and also being mindful of the negative sides of this method of feeding for which we are delighted to have Ruth Watling to present. We hope you will join in with the debate with our speakers.

In the afternoon we will join with the Trainees for abstracts and information about getting into research. We will also hear about the outcomes of post EEN nutrition audit from Joan Gavin and Mick Cullen is also going to share his experience of a month of EEN with insight into managing this treatment.

The ATM day is also a valuable opportunity for networking with other members and finding out the latest information from our generous sponsors. Please do visit the stands during the breaks. I would also like to thank the Alder Hey team for hosting the day and of course Carla for the hard work that has gone in to putting the programme together.

I look forward to meeting you and hope you enjoy the day!

Nicky Heather
Chair of the Associate Members of BSPGHAN

9.00 – 9.45

Registration

Institute in the Park Reception Area

9.45 – 10.00 Welcome

Large Lecture Theatre

Dr Kelsey Jones
SpR
Oxford University Hospitals
Oxford

and

Ms Nicky Heather
Dietitian
Nutrition & Dietetic Department
Southampton General Hospital
Tremona Road, Southampton

10.00 – 11.20 Parallel Session 1:

Parallel Trainees (Large Lecture Theatre) and Associate Members Sessions (Small Lecture Theatre)

Chair:

Huey Miin Lee
SpR
King's College Hospital
London

10.00 – 10.25 ***H. pylori:*** **Epidemiology and approaches to diagnosis in the UK**

Dr Richard Hansen
Consultant Paediatric Gastroenterologist
Royal Hospital for Children
1345 Govan Road
Glasgow G51 4TF

10.25 – 10.50 ***Pancreatitis: Lessons from Europac***

Prof John Neoptolemos
Royal Liverpool University Hospital
Daulby St
Merseyside

10.50 – 11.20 ***Hepatic Tumours: General Overview for PGHAN Specialists***

Mr Michael Dawrant
Consultant Paediatric Surgeon
Leeds General Infirmary
Leeds

Chair:

Mr Mick Cullen
Paediatric Gastro Nurse Specialist
Southampton General Hospital
Tremona Road, Southampton

10.00 – 10.25 ***Glasgow research on blended diets*** Discussion on Publication and Survey

Mr Chris Smith
Dietitian
Dept of Nutrition and Dietetics
Royal Alexandra Hospital
Brighton

10.25 – 10.50 ***Problems and risks associated with blended diet***

Ms Ruth Watling
Dietetic Manager
Alder Hey Children's Hospital
East Prescot Rd, Liverpool

10.50 – 11.20 ***Patient experiences of blended diet***

Patient details to be confirmed on day

11.20 – 11.40

Coffee Break and opportunity to visit sponsor stands

Reception Area

11.40 – 12.30 Parallel Session II

Chair:

Dr Rachel Levi
Clinical Lecturer Paediatric Gastroenterology
Royal London Hospital
Pond Street, London

11.40 – 12.05 ***Feeding the neurodisabled child***

Dr Krishnappa Venkatesh
Consultant Paediatric Gastroenterologist
East Prescot Rd
Liverpool L14 5AB

12.05 – 12.30 ***Obesity: Diagnosis of metabolic and other complications: When to refer?***

Dr Mohammed Didi
Consultant Paediatric Endocrinologist
Alder Hey Hospital
East Prescot Road
Liverpool

Chair:

Ms Emma Jones
Dietitian
Alder Hey Hospital
East Prescot Road
Liverpool

11.40 – 12.30 ***Panel discussion on blended diets and what is happening nationally and locally***

Panel members

Against:
Ms Ruth Watling
Dietetic Manager
Alder Hey Children's Hospital
East Prescot Rd
Liverpool L14 5AB

For:
Ms Claire Sadlier
Specialist Nurse
Children's Centre
University Hospital Wales
Heath Park
Cardiff

12.30 – 13.30

Lunch and opportunity to visit sponsor stands

Joint Associate Members and Trainees Session
Large Lecture Theatre

13.30 – 14.30 ***Research Session***

Chairs:

Dr Nicola Ruth	Ms Claire Lee
SpR	Paediatric Gastroenterology Research Nurse
Liver Unit	Addenbrooke's Children's Hospital
BCH	Hills Road
Birmingham	Cambridge

13.30 – 13.45 ***Research Overview***

Professor Stephen Allen
Professor of Paediatrics / Honorary Consultant Paediatrician
Room M-215 Department of Clinical Sciences
Liverpool School of Tropical Medicine, Liverpool

13.45 – 14.00 ***Research involvement for busy clinicians***

Dr Anna Pigott
Consultant Paediatric Gastroenterologist
City General Hospital
University Hospital of North Staffordshire
Newcastle Road, Stoke-on-Trent

14.00 – 14.30 ***Research Presentations***

14.00 – 14.10 ***Awareness of ESPGHAN guidelines on coeliac disease amongst general paediatricians in South West England***

Helen Adams
Bristol Royal Hospital for Children
Upper Maudlin Street, Bristol

14.10 – 14.20 ***The Gut Microbiome-Immune Axis with Treatment in Paediatric Inflammatory Bowel Disease***

Dr Intan Yeop
Clinical Research Fellow in Paediatric Gastroenterology
UCL GOS
30 Guilford Street, London

14.20 – 14.30 ***Schistosomiasis***

Cortland Linder, James Penney and Dr Stephen Spencer
Medical Students
University of Manchester
Oxford Road
Manchester

14.30 – 14.55

Abstract Presentations/Interesting Case Presentations

Chairs

Dr Robert Hegarty
Specialist Registrar
Kings College Hospital
Denmark Hill
London

Mr Chris Smith
Dietitian
Dept of Nutrition and Dietetics
Royal Alexandra Children's Hospital
Eastern Road, Brighton

14.30 – 14.38 ***A case of colonic tuberculosis mimicking Crohn's disease***

Dr Huey Miin Lee
Paediatric Gastro Grid ST6
Royal London Hospital
Whitechapel Road, London

14.38 – 14.46 ***Refractory IBD***

Dr Anastasia Konidari
Specialist Registrar
Royal Manchester Children's Hospital
Oxford Road, Manchester

14.46 – 14.54 ***Combined Pelvic Organ Prolapse: Case report in a paediatric patient***

Dr S D Mohammed
Lower GI Physiology Unit Manager
The Royal London Hospital
The Wingate Institute
26 Ashfield Street, Whitechapel, London

14.55 – 15.10

Coffee

15.10 – 16.50

Chairs:	
Dr Anastasia Konidari	Ms Nicky Heather
SpR	Nutrition and Dietetic Dept
Manchester Children's Hospital	Southampton General Hospital
Oxford Road	Tremona Road
Manchester	Southampton

15.10 – 15.35 ***Maintenance enteral nutrition post induction therapy in newly diagnosed paediatric Crohn's disease. Does 600kcals more per day keep the doctor away?***

Ms Joan Gavin
Dietitian
Nutrition and Dietetic Department
Southampton General Hospital
Tremona Road, Southampton

15.35 – 16.00 ***C. diff : When and how to treat***

Dr Richard Cooke, FRCP FRCPath
Consultant Medical Microbiologist & DIPC
Honorary Senior Lecturer in Medical Microbiology, University of Liverpool
Alder Hey Children's NHS Foundation Trust
East Prescot Road
Liverpool
L14 5AB

16.00 – 16.25 ***Modulen March***

Mr Mick Cullen
Paediatric Gastro Nurse Specialist
Southampton General Hospital
Tremona Road, Southampton

16.25 – 16.50 ***New biologics in IBD***

Dr Sandhia Naik
Consultant Paediatric Gastroenterologist
Training Programme Director
Royal London Hospital
Barts Health NHS Trust, London

16.50 – 17.00 **Prize Presentation**

Stephen Allen and Sandhia Naik

Close of meeting

Ms Nicky Heather and Dr Kelsey Jones

Selected Abstracts

Awareness of ESPGHAN Guidelines on coeliac disease amongst general paediatricians in Southwest England

Helen Adams, Dharam Basude, Siba Paul
Bristol Royal Hospital for Children

Background:

ESPGHAN 2012 guidelines on paediatric coeliac disease (CD) recommend that symptomatic children with anti-tissue transglutaminase titres (tTG) > 10 x the upper limit of normal (ULN), positive anti-endomysial antibody (EMA) results, and who are HLA DQ2/8 positive, can be diagnosed without a biopsy. However, non-biopsy diagnosis is not appropriate for certain groups of patients who continue to require a biopsy; this includes asymptomatic individuals with conditions associated with CD and those with tTG<10xULN. Adequate knowledge of the ESPGHAN guidelines is required by general paediatricians to ensure suspected CD patients undergo appropriate investigations for an accurate diagnosis.

Aims:

1) To gain an understanding of awareness and use of ESPGHAN guidelines for diagnosing CD in children amongst general paediatricians

2) Provide recommendations to increase awareness if required.

Methods:

A telephone/email survey was conducted of general paediatric consultants (n≈160) across Southwest England with 11 DGHs. 8 questions were asked to assess awareness and use of ESPGHAN guidelines, incorporating 3 main themes: when non-biopsy diagnoses can be made, when HLA-DQ2/8 genotyping should be requested and whether asymptomatic children from high-risk groups with tTG>10xULN can be diagnosed without a biopsy.

Results:

46 responses obtained. 96% paediatricians are aware of ESPGHAN guidelines and non-biopsy/biopsy pathways for diagnosing CD. 80% of paediatricians were unable to state all conditions required for non-biopsy diagnosis. None could describe all appropriate situations where HLA-DQ2/8 genotyping should be requested. 33% of paediatricians responded that asymptomatic children with tTG>10xULN can be diagnosed with CD without a biopsy while 26% said they were unsure or would seek advice.

Conclusions:

Survey highlighted need for greater in-depth awareness of non-biopsy pathway and situations where HLA-DQ2/8 genotyping is indicated. There is possible misinterpretation regarding the ESPGHAN guidelines as 1/3rd of paediatricians considered non-biopsy pathway is applicable to asymptomatic children with tTG>10xULN. There is need for improved understanding of the ESPGHAN guidelines amongst DGH paediatricians.

The Gut Microbiome-Immune Axis with Treatment In Paediatric Bowel Disease

Dr Intan Yeop, Clinical Research Fellow in Paediatric Gastroenterology, UCL, GOS. 3- Guilford Street, London

Increasing evidence indicates that genetic susceptibility, dysbiotic gut microbiome and altered immunity are key determinants of Inflammatory Bowel Disease (IBD) pathogenesis. Children account for 25% of IBD patients, with the incidence continuing to rise (1). PIBD can be more aggressive and extensive, and is associated with significant morbidity affecting growth, development, education and well-being of children.

The gut microbiome of IBD patients differs from that of healthy individuals. Firmicutes and Bacteroides dominate in health but in IBD, there is dysbiosis, or microbial imbalance, with reduced bacterial diversity) Gut microbiota alters with treatment, with relapse and remission, and disease severity. It is tempting to hypothesise that treatment, when successful, does so by restoring dysbiotic microbiome to a symbiotic state leading to immune harmony.

Resident gut bacteria also influence the host by producing metabolites, i.e. microbial metabolome, from ingested food. It has been reported that high fibre and fruit intake reduces CD risk, and high vegetable intake reduces UC risk (2). In addition, short chain fatty acids (SCFA), produced from fermentation of dietary fibres, correlate with disease activity.

We hypothesise that gut microbiome composition and function (metabolome) influences disease relapse, severity and response to treatment, and these in turn affects the systemic inflammatory profile. Bacterial DNA is extracted from mucosal biopsies, duodenal lavages and stool samples. DNA extracts are then amplified using a 16s rDNA specific PCR and then sequenced using next generation sequencing. Stool SCFA content is quantified using gas chromatography and plasma cytokines concentration is analysed by Meso Scale Discovery Multiplex Assay. Samples are collected prospectively from patients with newly-diagnosed IBD, severe IBD and starting Infliximab and compared with samples from non-inflamed controls. It is hoped that the results will bring us a step closer to understanding the interaction between gut microbiota and the paediatric host immunity.

References

1. British Society of Paediatric Gastroenterology, Hepatology and Nutrition. (2008). Guidelines for the Management of Inflammatory Bowel DIsease (IBD) in Children in the United Kingdom.
2. HOU JK, A. B.-S. Dietary intake and risk of developing inflammatory bowel disease: a systematic review of the literature. Am J Gastroenterol 2011 Apr;106(4):563-73.

Background:

I had been keen to do undertake research in immunity in paediatric Inflammatory Bowel Disease. When designing my PhD project, I was drawn to the gut microbiome as a newly-established factor in Inflammatory Bowel Disease.

As the gut microbiota interacts closely with the host immune system, it became clear that I needed to investigate both factors to understand changes with IBD treatment. Dietary intake influences the gut microbiota, and the gut microbiome has been shown to be associated with changes in clinical status. I thus realised that this area could offer a genuine

opportunity to contribute to clinical management of IBD patients. However, it would be ideal to understand the interactions better before embarking on interventional studies.

Methods:

Clinical and basic nutritional details that can influence the gut microbiome are collected alongside patient samples.

Samples are analysed for;

- Gut microbiome – Gut tissue, duodenal lavages and stool samples are collected and stored. DNA extraction is performed in batches before analysis by 16S rDNA sequencing using MiSeq System.

- Gut metabolome – Stool samples are preserved and stored. After freeze-drying, short chain fatty acids are extracted in batches and analysed using gas chromatography.

- Host immunity – Plasma is extracted from blood for cytokine analysis using MSD Multiplex Assay.

The methodology of the study, the reasons for choosing the methods, possible alternatives, optimisation of the methods and potential benefits/ disadvantages of the methods will be discussed further depending on time available.

Results:

To be discussed at a later date.

Next Steps:

Sample collection is almost complete. The final laboratory work is currently underway. Data analysis of pilot data is currently taking place but further data analysis and interpretation will take place in 2017.

Schistosomiasis

Cortland Linder[*], James Penney[*], Dr Stephen Spencer[**]
[*]5th year medical students, [**]Final year medical student; University of Manchester, Oxford Road, Manchester

Introduction:

Schistosomiasis is a parasitic disease that infects humans through contact with water. It is extremely widespread throughout sub-Saharan Africa and the full affect of the disease worldwide is underestimated. Long-term infection can cause diarrhoea, liver damage and development delay. While schistosomiasis is prevalent in Madagascar, there has been little effort by the government to treat the disease. In 2015, a team from the University of Manchester travelled to six villages along the Nosivolo River in the remote Marolambo District. Here they found that, alarmingly, 94% of children had Schistosomiasis.

In June 2016 a team of 10 medical students and doctors from the UK and Madagascar returned to the same villages in Marolambo. This year the team researched the burden of Schistosomiasis on children in the villages. To do this they used questionnaires, bedside tests, shuttle run tests and microscopy. They also investigated changes in the liver associated with Schistosomiasis, using a portable ultrasound with solar panels and power banks. The team ran education programs to encourage good hygiene and explain Schistosomiasis transmission. Finally, the children in each village were treated for Schistosomiasis in accordance with World Health Organisation guidelines.

Preliminary analysis showed that almost all (97%) of the children investigated have Schistosomiasis. Furthermore, the average child had a high level of infection, with more than half reporting symptoms associated with Schistosomiasis. Altogether, it is likely that these children are sick from Schistosomiasis. This may have an impact on school attendance, social and physical development and economic contribution. Following further analysis of the data, the team plans on returning to the region to continue treatment and education programs. The level of illness caused by Schistosomiasis will be reassessed regularly to evaluate the efficacy of intervention.

Schistosomiasis is a neglected tropical disease, with a large, underestimated burden worldwide. It is known to be extremely prevalent in Madagascar, although only 27% of the country was treated in 2014 with the chemotherapy Praziquantel. In 2015, a team of the same members from the University of Manchester found that 94% of children in villages in the Marolambo District had the hepato-splenic variant *Schistosomiasis mansoni.* Against this alarmingly high finding of hyperendemnicity, we resolved to assess the burden of the disease in the area. With this we can establish the baseline morbidity in the region. The project was sponsored by organisations such as the Scientific Exploration Society, the Royal Geographical Society and the University of Manchester.

Subjects and Methods:

We investigated 300 children in 6 isolated villages that lay along the Nosivolo River. We spent three days in each village, performing research, running education programs and administering treatment to all children. We transported all our research equipment between villages on foot with the help of porters through tropical terrain. In each village, we set up

stations in wooden huts, using solar panels and power banks to charge equipment needed for the expedition.

We planned our research methods with advice from experts at the London and Liverpool School of Tropical Hygiene and Medicine. In order to assess the morbidity of Schistosomiasis, we distributed a structured questionnaire, inquiring about current symptoms and water contact behaviour. We used the Paediatric Quality of Life Inventory to assess health related quality of life. We performed liver ultrasound in the field, looking for liver changes as a result of Schistosomiasis according to the Niamey protocol. During this test, we also felt abdomens for obvious livers and spleens. To assess for stunting and malnutrition, we measured height, weight and arm circumference. The children were assessed for anaemia and malaria using point of care tests and for cardiovascular fitness by 20-meter shuttle run (bleep test). Urine antigen analysis (CCA) was used to determine Schistosomiasis prevalence. Finally, we calculated infection intensity by performing light microscopy of faeces using Kato-Katz technique.

Results:

Results are still undergoing analysis. However, preliminary results show that 97.6% of the children in the villages had Schistosomiasis. The average intensity of infection was 325 eggs per gram, which is classified as moderate infection. These results show the need for regular mass drug administrations of Praziquantel to reduce Schistosomiasis related morbidity.

65% of participants reported one symptom, most commonly cough (27%) and diarrhoea (25%). Our clinical examination revealed that almost 20% had hepatomegaly, and 13% had splenomegaly. Finally, 25% had malaria. While many of these findings are non-specific, these results nevertheless indicate that these children are ill.

Next steps:
Our plan is to continue student-led expeditions to the Marolambo region for the next five years. In accordance with World Health Organisation guidelines and with the help of the Ministry of Health of Madagascar, we will expand the treatment program to cover all villages in the Marolambo District. We will also develop the education program; in particular, we want to encourage local involvement in Schistosomiasis education and drug administration, so that the project is sustainable. We will reassess disease morbidity to further tailor management to the villages and determine it efficacy.

A case of colonic tuberculosis mimicking Crohn's disease

Dr Huey Miin Lee, Paediatric Gastro Grid ST6, Royal London Hospital, London

An 11-year-old girl was admitted to her local hospital for a 2-week history of intermittent malaena and haematochezia. She denied change of bowel habit. Admission haemoglobin was 86 and she was transfused with a unit of blood when there was drop of haemoglobin. She was started on omeprazole 20mg OD and admitted to our tertiary GI unit on 9.2.2016 for upper and lower GI endoscopy with biopsies which showed right-sided colitis with bleeding, erythema and pseudo-polypoid lesions. Her histology showed active chronic inflammation in keeping with Crohn's colitis. She was readmitted to our tertiary GI unit electively to commence Modulen. A TB ELISPOT was performed and it came back as positive during the admission. A Mantoux test was done on 26.2.2016 and this was also positive. She had MRI small bowel on 22.3.2016 which showed active disease in caecum involving ileo-caecal valve with sparing of terminal ileum. She completed a 6-week course of Modulen treatment and had a repeat colonoscopy. Microbiology culture from her biopsies grew Mycobacterium tuberculosis. She was thus commenced on anti-tuberculosis treatment. This case highlights the importance of screening for TB in patients diagnosed with inflammatory bowel disease and shares our experience in managing colonic TB.

Refractory IBD

Inflammatory bowel disease..perhaps not
Konidari A., Jago L.,Thomas A., Fagbemi A. Royal Manchester Children's Hospital

Presenting symptoms

Eleven year old boy who presented with weight loss, fatigue, abdominal pain, lip swelling and mouth ulcers.

Clinical examination and diagnostic work up

weight 43.6 kg-(2nd) / height 131.5 cm (75-91st)
Paleness, mild abdominal tenderness, perianal skin tag
Investigations revealed anaemia, raised platelet count and inflammatory markers, low albumin
Diagnostic endoscopy/histology confirmed Crohn's disease.
Barium showed areas of narrowing in transverse colon, active inflammation TI (3 cm), long segment small bowel disease

Past medical history

Hidradenitis suppurativa

Management

Antibiotics, polymeric diet, 5ASA, azathioprine.

Progress

Re-admitted with skin abscesses, recurrent abdominal pain. Subsequently presented with peri-anal and left buttock abscess requiring drainage. Trial of anti-TNF, referred to immunology.

Outcome/Discussion

Abnormal neutrophil function tests were observed.
Strongly diminished NADPH oxidase activity due to an homozygous new mutation in NCF2, the gene for p67-phox (c.620C>A p.Ser207Tyr), confirmed the diagnosis of chronic granulomatous disease (CGD).
Patient was commenced on long term antibiotics/anti-fungals and is listed for stem cell transplant.

Take home message

Children and young adults with refractory IBD should mandatorily be tested for CGD

Combined Pelvic Organ Prolapse: Case report in a paediatric patient

Mohammed SD; Rawat D; Scott SM;

The Royal London Hospital, The Wingate Institute, 26 Ashfield Street, Whitechapel, London

Introduction: Rectocoele and rectal intussusception are potential components of pelvic organ prolapse. They typically present with symptoms of evacuatory dysfunction and constipation. However, both are rare in the paediatric age group and only very few reports are documented in the paediatric literature. Lower gastrointestinal physiological (GI) and radiology testing (including defaecography and transit studies) are important in evaluating underlying colonic/anorectal disorders.

Clinical presentation: a 12-year-old girl gives a one-year history of persistent abdominal pain and constipation. She is dependent upon regular laxatives to open her bowels. This is on a background history of chronic abdominal pain dating back to age 5 and which was labelled as *'irritable bowel syndrome'*. She denies a history of frank faecal leakage and rectal bleeding.

Investigations: GI transit and rectal sensation were normal. High-resolution anorectal manometry and endoanal ultrasound showed normal anal sphincter function and morphology. Interestingly, defaecography revealed a functional rectocoele (3.5 cm) along with a striking obstructing recto-anal intussusception.

Conclusion: the specific etiology of these abnormalities is unclear; given the age of the patient, it is likely that such abnormalities result from weakness or abnormalities in pelvic floor support and underlying connective tissues.