were included. Exclusion criteria: outpatient and A&E attendances, telephone consultations.

Results Between 2004 and 2011 the mean inpatient readmission rate for medical detoxification was 26.7% (484 readmissions, 1813 total admissions). On average 22.4% of medical and surgical inpatients were readmitted over the 7-year period (293 readmitted/1512 total admissions). Both the yearly readmission rate and percentage of patients requiring readmission increased by 589% and 689% respectively between 2004 and 2011, peaking in 2008–2009 predominantly due to an increase in patients readmitted once (four patients in 2004–2005 compared to 67 patients in 2008–2009). On average patients were readmitted 2.5 times for detoxification. The average period between readmissions was 9.4 months. 10% of patients were re-admitted for detoxification more than 5 times in this period (mode 6 readmissions, range 6–23 readmissions).

Conclusion Admission rates for inpatient detoxification are high. However, <25% of patients require readmission and only a minority require more than five detoxifications, thereby reflecting the efficacy of the ASN and Alcohol Care Team in minimising revolving door patients and the economic cost incurred. We recommend that all general hospitals should offer this service to effectively manage alcohol misuse.

Abstract PTU-261 Table 1

	% Patients readmitted (absolute value/total patients)	% Readmissions (absolute value/total admissions)
Year		
April 2004–March 2005	3.9 (6/154)	4.6 (8/174)
2005–2006	19.5 (32/267)	15.4 (52/337)
2006–2007	14.2 (22/155)	20.3 (40/197)
2007–2008	19.0 (33/174)	22.7 (51/225)
2008–2009	40.6 (89/219)	43.1 (132/307)
2009–2010	17.8 (49/275)	39.5 (98/248)
2010–2011	23.1 (62/268)	31.7 (103/325)

Competing interests None declared.

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PTU-262 ALCOHOL-MISUSE AND INPATIENT DETOXIFICATION: THE INCREASING WORKLOAD AND IMPACT OF AN ALCOHOL CARE TEAM AND ALCOHOL SPECIALIST NURSE (ASN) IN A DISTRICT GENERAL HOSPITAL

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Introduction The prevalence of alcohol misuse has risen dramatically over the past decade with younger individuals (aged 16–44 years) and women increasingly affected.[1] In 2007 24% adults were classified as hazardous drinkers (33% men, 16% women).[2] Over a 15-year period hospital admission rates for alcohol-related disorders have doubled,[3] with significant social and economic consequences. Recently, The British Society of Gastroenterology and NICE recommended an Alcohol Care Team including an ASN in every District General Hospitals to ensure early and effective inpatient treatment of patients with alcohol misuse; maximising compliance and reducing relapse. Studies indicate that an ASN generates 400 fewer admissions per year with shorter durations of stay and lower mortality rates.[4]

Methods We retrospectively audited the impact of the ASN on rates of inpatient referrals and medical detoxification regimes undertaken between 2004 and 2011 at Bassetlaw District General Hospital. Rates of commenced and completed detoxifications in addition to self-discharge data were obtained. Medical and surgical inpatients were included. Exclusion criteria: outpatient and A&E attendances, telephone referrals.

Results Between 2004 and 2011 the number of inpatient referrals for medical detoxification increased BY 657% (49–371 referrals per year). On average, the majority of inpatients were male (66%) and 48 years of age (range 17–90 years). Over a 7-year period the number of inpatient detoxifications commenced increased by 600% (24–168 detoxifications per year). Similarly, completed detoxifications increased by 517% (23 and 142 completed detoxifications in 2004 and 2011 respectively). On average 90.8% (714/786) detoxifications were completed prior to discharge. 9.2% (72/786) patients self-discharged prior to completing the detoxification regime.

Conclusion The workload of the Alcohol Care Team and ASN has increased substantially over a 7-year period, reflecting the rising prevalence of alcohol misuse and alcohol-related disease. The ASN provides early recognition and implementation of medical detoxification regimes for inpatients, offering support and continuity of care to maximise compliance and efficacy of treatment. Greater recognition and investment in alcohol services is essential within all UK District General Hospitals to minimise the growing burden of alcohol misuse.

Competing interests None declared.

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PTU-263 IS IT TIME FOR GASTROENTEROLOGY AND GENERAL MEDICINE TO GO THEIR SEPARATE WAYS?

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Introduction Currently most gastroenterologists within the UK are general physicians with a specialist interest in gastroenterology (85%) and most gastroenterology (GI) trainees train for dual accreditation in GI and general internal medicine (GIM). They therefore commit a major part of their time to the management of patients with GIM problems as part of their unselected acute medical take and ward work. With the development of "acute medicine" as a specialty in its own right and the formation of specialty-based wards to care for medical in-patients it has been questioned whether gastroenterologists should train to obtain dual accreditation in GI and GIM. The increasing demands for provision of GI services further support the conflict of whether training in GIM is required. With this in mind, we aimed to assess patients admitted with a primary GI complaint that should be triaged to a GI ward, the number of acute (active) non-GI diagnoses requiring acute treatment and whether these were managed by gastroenterology or whether referral to a specialist team was made.

Methods A single centre, prospective analysis of all patients admitted with a primary GI diagnosis during the unselected general medical take over a 6-week period (November 2011–January 2012)

was made. Chase Farm Hospital is a district general hospital that has a clinical decision unit, a short stay ward along with a speciality based ward triage for GIM patients. Data were obtained from medical notes and discharge summaries.

Results 62 patients (29 male, 33 female), median age 72.5 years were admitted over the study period. 38 patients (61.3%) had no other acute non-GI diagnoses requiring prompt treatment. 24 patients (38.7%) had at least one other non-GI diagnosis (range 1–2): 16 patients (25.8%) had one and eight patients (12.9%) had two active non-GI diagnosis. The most common non-GI diagnosis was cardiovascular in origin (9, 37.5%). Other non-GI diagnoses were respiratory (6, 25%), renal (6, 25%), endocrine (6, 25%), or other (4, 16.6%). Of these patients, 5 (20.8%) required referral to a specialist team for further investigation and/or treatment of their condition.

Conclusion A significant number of patients (~39%) admitted as an acute medical emergency with a primary GI diagnosis have other active non-GI medical diagnoses. The majority of these were managed by gastroenterology and only in one in five patients was a specilaist opinion sort for further management. By training and maintaining skills in GIM, gastroenterologists are more able to independently manage acute medical patients admitted with a primary GI diagnosis and avoid inter-specialty referral in up to 25% of patients. From this study we support the dual accreditation sought by gastroenterology trainees in GIM.

Competing interests None declared.

PTU-264 PROVIDING A COLONIC STENTING SERVICE FOR MALIGNANT BOWEL OBSTRUCTION: A DISTRICT GENERAL HOSPITAL EXPERIENCE

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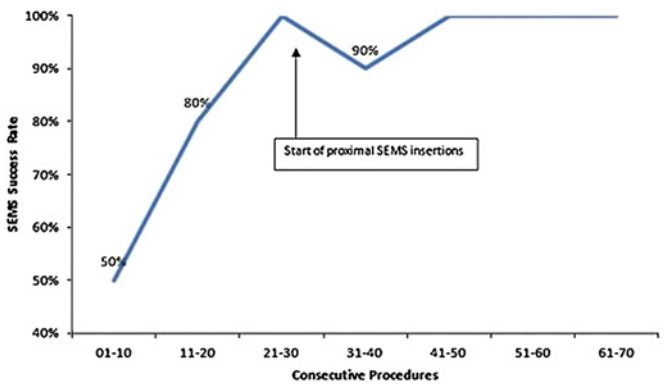
Introduction There is growing evidence for the efficacy and safety for the insertion of self expanding metal stents (SEMS) in the treatment of acute malignant colonic obstruction.[1] This allows either palliation or a bridge to surgery in an otherwise acutely unwell patient. Colonic stenting literature quotes technical success rates in excess of 85%.[1–4] Our unit has been inserting colonic SEMS since 2006. Prior to this we had extensive experience in therapeutic endoscopy but not in colonic stenting. We have observed a learning curve with colonic stenting that is encouraging for endoscopists who are considering implementing the technique.

Methods All SEMS insertions from July 2006 to December 2011 were analysed retrospectively by examining a combination of endoscopy reports, the CRC database and patient notes. A successful SEMS deployment was defined as: satisfactory radiological and endoscopic evidence of colonic decompression at time of deployment and clinical improvement. All SEMS insertion successes and failures were collated and the data compared in consecutive groups of ten procedures.

Results 70 SEMS insertions were attempted in 62 patients. Each procedure is carried out endoscopically with radiological guidance by a gastroenterologist. Ten (14.3%) of the stents were proximal to the splenic flexure. The overall success rate for SEMS deployment was 88.6% (n=62). Abstract PTU-264 figure 1 shows the success rates improvement with the number of procedures carried out. 7 of the 8 failures occurred in the first 20 procedures carried out in our unit. Reasons for unsuccessful procedures are failure to traverse stricture with guidewire (n=5), stent slippage (n=2) and poor bowel prep & excessive looping (n=1). Overall complications rates were low. There were two perforations (2.9%), one of which underwent emergency surgery while the other was managed conservatively. Restenosis occurred in two patients (2.9%) and tumour overgrowth occurred in 1 (1.4%).



Abstract PTU-264 Figure 1

Conclusion SEMS technology is now readily available and is a safe and effective means of treating malignant colonic obstruction. As with all new techniques there is a learning curve associated with its implementation. We have shown that the learning curve is surmountable and that potentially any unit could offer a colonic SEMS service.

Competing interests None declared.

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PTU-265 IMPROVING EDUCATION QUALITY AND ATTENDANCE OF A REGIONALLY DELIVERED GASTROENTEROLOGY EDUCATION PROGRAMME

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Introduction The 2010 competency based speciality-training curriculum for gastroenterology requires trainee's to obtain multiple learning objectives. To ensure these are met training programme directors and postgraduate deaneries need to implement changes in delivery of local education programmes. The aim of this study was to determine factors in the delivery of a locally organised and delivered gastroenterology teaching programme that have the greatest impact on improving educational quality and attendance.

Methods All consultants and gastroenterology trainees within a deanery received a questionnaire evaluating the 2009–2010 competency based training programme. Responses were compared with data obtained evaluating a previous training programme between 2003 and 2009 designed around the 2003 gastroenterology curriculum involving 6-weekly, half day events at local hospitals organised by individual consultants. Significant interventions made to the new programme included a predetermined programme guide, whole day events, single venue, keynote speakers, continual professional development points, a local training website and increased trainee involvement in programme development.