

Introduction Patients with CBD (Common Bile Duct) stones require high risk interventions. Around 10–20% patients with symptomatic gallstones have CBD stones. Where the initial clinical, biochemical and ultrasound examinations failed to correctly predict CBD stones in a patient with gall stones, one should resort to either MRCP or EUS (Endoscopic Ultrasound) depending on the local expertise. Without the availability of either national or local proposed strategy for these investigations we feel either test may be inappropriately used. Our aim was to study the clinical details of patients undergoing MRCP for the suspected CBD stones and assess for their appropriateness.

Methods We randomly selected 45 patients who underwent MRCP for suspected CBD stones in the last one year. We assigned the risk of choledocholithiasis based on ASGE (American Society Gastrointestinal Endoscopy) guidelines and compared with their suggested management strategy. Finally we assessed their appropriateness based on the predictive factors and MRCP findings.

Results There were 28 females and 17 males. The age range was 21 to 91 years (mean 63.7 yrs). Based on the ASGE guidelines we assigned 24 (53.33%) patients to intermediate, 16 to low (35.55%) % and 5(11.11%) to high likelihood of choledocholithiasis based on clinical predictors. Only 6 patients (13.33%) had choledocholithiasis on MRCP three in high risk (3/5), 3(3/24) in intermediate risks and none (0/16) in low risk group

Conclusion Our audit suggests inappropriate use of MRCP in patients with low predictable group (35%). We feel those patients with high predictability should be carefully considered directly for ERCP. Currently we are extending this audit and also plan to re-audit after formulating local guidelines for the use of MRCP in suspected bile duct stones. We feel with careful clinical judgement, MRCP can be used selectively in those patients where it is going to be more useful and saving these radiological slots for more needy patients in a busy DGH.

Disclosure of Interest None Declared.

REFERENCES

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2. The role of endoscopy in the evaluation of suspected choledocholithiasis- ASGE Guidelines GI Endoscopy Vol 71, No 1 2010

PTH-128 THE FRAX ALGORITHM IS OF LIMITED UTILITY IN PREDICTING OSTEOPOROSIS IN COELIAC DISEASE

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Introduction Osteoporosis is the commonest complication of coeliac disease yet no reliable scoring system exists to guide patient selection for bone density measurement. The FRAX tool has been developed by the World Health Organisation to estimate fracture risk based on clinical factors and incorporates causes of secondary osteoporosis such as coeliac disease (1). We have analysed the utility of FRAX in identifying osteoporosis in a cohort of patients with coeliac disease.

Methods 170 patients were recruited from coeliac clinics between October 2011 and 2012. 17 patients in whom bone mineral density results were not available were excluded, yielding a final study population of 153. Information on clinical risk factors for osteoporosis were collected by questionnaire. Two-tailed independent student t-tests, Mann Whitney U test or Chi-square tests were applied as appropriate. Statistical analysis was performed on SPSS.

Results

Abstract PTH-128 Table 1

Risk Factor	Controls (n = 130)	Patients (n = 23)	Osteoporotic p-value
Age at DEXA, mean (IQR)	52.4yrs (22.2)	69.6yrs (13.36)	< 0.001
Sex (Female)	91 (70%)	17 (73.9%)	0.895
Weight, mean (IQR)	67.9kg (16)	60.4kg (12.2)	0.001
Height, mean ± S.D.	166cm ± 8.36	162cm ± 7.78	0.023
History low trauma fracture	7 (5.5%)	4 (17.4%)	0.067
Family history of osteoporosis	27 (20.9%)	5 (21.7%)	1.000
Current smoker	14 (10.8%)	5 (21.7%)	0.168
History of glucocorticoid use	5 (3.9%)	4 (18.2%)	0.034
Alcohol, > 3units/week	10(7.8%)	1 (4.3%)	0.567

The prevalence of osteoporosis in our cohort was 15% (23/153). The distribution of risk factors used in the FRAX algorithm are shown in table 1. Factors significantly associated with osteoporosis in our cohort included increasing age, reduced height, weight and history of glucocorticoid use. The median 10 year risk of major osteoporotic fracture was 6.7% (interquartile range 8.5). A ROC analysis of FRAX as a predictor of osteoporosis yielded an area under the curve of just 0.614.

Conclusion The FRAX algorithm is not a reliable predictor of osteoporosis. A screening threshold of > 10% 10 year risk of major fracture gives a sensitivity of 43% and specificity of 73% for detection of osteoporosis. A lower threshold of 5% 10 year risk only increases sensitivity to 78% at a cost to specificity of 59%. Further work in constructing specific risk predictors for osteoporosis in coeliac disease is required.

Disclosure of Interest None Declared.

REFERENCE

1. Kanis JA et al. (2008) FRAX™ and the assessment of fracture probability in men and women from the UK. *Osteoporosis International* 19: 385–397.

PTH-129 DEVELOPMENT AND ASSESSMENT OF A PATIENT INFORMATION LEAFLET RELATING TO THE HARMFUL EFFECTS OF EXCESSIVE ALCOHOL CONSUMPTION. A PROSPECTIVE SURVEY FROM A DISTRICT GENERAL HOSPITAL

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Introduction Alcohol abuse is a major cause of preventable liver disease world wide. Alcohol related liver disease and associated death is rising at an alarming rate whilst all other causes of death are falling in the UK¹. 38% of men and 16% of women (aged 16–64) misuse alcohol in England¹. It is estimated that there are 7.1million hazardous or harmful drinkers and 1.1million dependent drinkers² in the UK. The East Cheshire NHS Trust was not utilising an effective patient information leaflet relating to the harmful effects of excessive alcohol consumption. Such leaflets can be vital in effective patient/public education, patient management and in aiding with altering health related behaviours.

Methods A working group was established to develop the leaflet. *Alcohol Related Disease: Meeting the Challenge of Improved Quality of care and Better Use of Resources*, produced by the BSG, was the source of much of the statistics and data used in the leaflet¹. Questionnaires were distributed and results were collated prospectively.

Results 49 questionnaires were returned. 34 female and 15 male. 53% of people reported they had never seen a leaflet like this before, with 63% stating that they were surprised by the extent of the

social, economic and health implications of excessive alcohol consumption. 51% stated that reading this leaflet would alter their alcohol consumption, with 92% stating they would pass the leaflet on to friends and family. 60% of people described the information as very easy to understand. 89% reported that the drink calculator was helpful in calculating their weekly alcohol consumption.

Conclusion Patient information leaflets play a vital role in patient education and altering health behaviours.

Our leaflet appears to convey the relevant information well and will allow for effective education, together with behaviour modification and may assist in the management of patients with alcohol related liver disease.

Larger prospective surveys are required to assess the impact of such leaflets and how they influence the long term management of such patients.

We propose an electronic campaign in the form of an information leaflet for the dissemination of information which would be cost effective, efficient and can be distributed reaching a wider population.

Disclosure of Interest None Declared.

REFERENCES

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PTH-130 FACILITATION OF BLOOD DONATION AMONGST HAEMOCHROMATOSIS PATIENTS: A UK PILOT

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Introduction The standard medical therapy for haemochromatosis is removal of iron by regular phlebotomy¹. Current EASL guidelines recommend that blood taken from uncomplicated haemochromatosis patients should be made available through national blood transfusion services¹. However, this practise varies widely across Europe and is often hindered by administrative difficulties. Here, we aim to describe a pilot facilitating the process of blood donation amongst haemochromatosis patients in the UK.

Methods A dedicated haemochromatosis clinic was established. At this clinic, patients with uncomplicated haemochromatosis interested in becoming blood donors were offered a simple information leaflet. One page provided information about eligibility; the second formed a self-referral application to be countersigned by the responsible physician. Upon receipt of referral, patients were contacted by members of the local Blood Service. Data on clinical characteristics including genotype, alcohol consumption, BMI, co-morbidities and previous blood donation was collected.

Results Patients attending (n = 101) since the introduction of this service (Aug 2011) are included. The median age was 57 (22–82) and the majority 70 (69%) were male. Most (89%) were C282Y homozygotes; the remainder were H63D/C282Y compound heterozygotes. The majority (91%) had uncomplicated haemochromatosis; however many were ineligible for blood donation by virtue of age (20%), co-morbidity (17%), or induction therapy (15%). Prior to the introduction of this service, there were 3 regular blood donors. Since the introduction of this service, of those potentially eligible (n = 40) 23 (58%) showed interest in blood donation, 20 (50%) applied, 17 (43%) are eligible and have registered. In total, there are now 13 regular blood donors, including 10 new who have donated 27 pints of blood (median 2[1–6]).

Conclusion There is an interest and willingness to donate blood through NHS Blood and Transplant amongst uncomplicated

haemochromatosis patients undergoing therapeutic phlebotomy. Since the introduction of this facilitation process, we have significantly increased the number of regular blood donors amongst this cohort. If this process was undertaken nationally or more widely across Europe, this could have a significant impact on the availability of this precious resource.

Disclosure of Interest None Declared.

REFERENCE

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PTH-131 FIRST YEAR RESULTS FROM A VIRTUAL IRON DEFICIENCY ANAEMIA SERVICE AT A DISTRICT GENERAL HOSPITAL

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Introduction Iron deficiency anaemia (IDA) has a prevalence of up to 5% in adult men and post-menopausal women, and is a common cause of referral to gastroenterologists. Important and common causes of IDA to exclude include coeliac disease (5%), gastric carcinoma (5%) and colonic carcinoma (5–10%). Despite this, IDA is not an indication for fast track referral at our institution. Recently the British Society of Gastroenterology (BSG) published guidelines for the investigation of IDA suggesting that all patients need oesophagogastroduodenoscopy (OGD), colonoscopy or computerised tomography (CT), urinalysis, and coeliac serology or duodenal biopsy. By establishing a virtual IDA clinic we aimed to ensure that our patients received these investigations within 4 weeks, without unnecessary follow up in a formal clinic.

Methods All requests for investigation of IDA are vetted by a band 7 nurse, investigations arranged and the results followed up with consultant support. A prospective database is maintained, and we report our first year results. Fisher's exact test was used to compare the prevalence of cancer in this group to all fast track cases referred for endoscopy at our institution over the same period.

Results 467 patients were referred with IDA: 189 male, mean age 71. 100% received an OGD and 96% received either a colonoscopy (81%) or CT (15%). Mean waiting times from initial referral were 24 days to OGD, 32 days to colonoscopy, and 52 days to CT. 54% had documented urinalysis results, but all patients' GPs were sent a letter advising urinalysis. 98% were investigated for coeliac disease, with serology (2%), duodenal biopsy (57%), or both (39%). Carcinoma was diagnosed in 9.2% (1.5% upper gastrointestinal carcinoma (n = 7), 7% colonic carcinoma (n = 31), and 1% other malignancy (renal tract (n = 3), lung (n = 1), and pancreatic (n = 1))). Coeliac disease was diagnosed in 3%. A potential cause for IDA was found in 35% of patients. Notably, there was a higher prevalence of carcinoma in the IDA group (9.2%) than in the fast-track endoscopy group (6.6%), however this was not statistically significant ($p = 0.08$).

Conclusion The virtual IDA service at this district general hospital meets the audit standards recommended by the BSG (> 90% screened for coeliac disease and > 90% receiving both upper and lower GI investigation). There was no significant difference in the prevalence of cancer in IDA patients compared to patients referred for fast-track endoscopy. In view of the high cancer detection rate we plan to investigate all IDA patients within 2 weeks, and recommend that other centres consider doing the same.

Disclosure of Interest None Declared.

REFERENCE

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