Conclusion A negative faecal calprotectin led directly to the avoidance of a colonoscopy in 12 patients and of small bowel investigation in 11 patients. Given the trust's current tariffs for faecal calprotectin, colonoscopy and small bowel meal and follow through, a total cost saving of £7,194.59 was made. Avoiding further investigation by waiting for a negative faecal calprotectin would have resulted in a greater cost saving.

Disclosure of Interest None Declared.

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PTH-137 PATIENTS' VIEWS ON THEIR EXPERIENCE OF THE DELIVERY OF SINGLE-SEX ACCOMMODATION WITHIN THE ENDOSCOPY DEPARTMENT: IS IT WORTH IT?

doi:10.1136/gutjnl-2013-304907.624

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Introduction The 2007 Chief Nursing Officer's report on privacy and dignity identified provision of single-sex accommodation (SSA) as a key objective for the NHS. This was formalised in the 2010 Department of Health (DOH) policy to eliminate mixed-sex accommodation and financial sanctions for policy breaches were introduced in 2011. Our endoscopy department adopted the policy in 2011. However the unit, which opened in 2004, has only one recovery bay, necessitating separate gender lists. Urgent procedures for patients of the opposite sex to the list running are accommodated by admission/recovery in a separate endoscopy room. We explored the views of patients on their experience of attending our unit since implementation of the SSA policy. There are no published studies of patients' perspectives of care in endoscopy units since the widespread adoption of the policy in 2011.

Methods Patients attending the endoscopy unit between August and October 2012 were invited to take part in the study by nursing staff during the admission process. Patient views were assessed using a structured non-disguised questionnaire of ten closed-ended questions. The Student's *t*-test was used and a p value of < 0.05 was taken to be significant.

Results Of the 68 questionnaires returned (female 20, male 25, unknown 23) 14 (20.6% [80% female]) and 17 (25% [81.8% female]) reported that they would feel vulnerable changing behind a curtain or waiting in a gown in a mixed-sex area respectively. Patients ranked (scale 1–10, 1 = least, 10 = most) the importance of provision of SSA significantly lower than the importance of access to prompt investigation and treatment (mean: 4.8 [SD ± 3.74] *vs* 8.71 [SD ± 2.70], $p = 2.6 \times 10^{-7}$). Male patients ranked the importance of SSA significantly lower than females (mean:1.5 [SD ±1.05] *vs* 6.5 [SD ±3.30], $p = 6.3 \times 10^{-6}$). 17/68 patients (25%) were admitted to an area other than the main receiving/recovery area because they were a different sex to the list running, and of these, 7/17 (41.2%) felt their care was compromised or patient experience reduced as a result.

Conclusion SSA delivery is important to our patients, especially women. However they rank prompt investigation and treatment as more important. The rapid introduction of SSA in our hospital, in the absence of the necessary infrastructure, conflicts in part, with the pressure to deliver timely investigations. This can lead to compromised care, notably in patients who are admitted/recovered in an alternative room and can also lead to delays for specialised endoscopy (polypectomy, ERCP and EUS). By making such compromises we are at risk of achieving no net gain in patient satisfaction and experience.

Disclosure of Interest None Declared.

PTH-138 ASSESSING THE POSITIVE PREDICTIVE VALUE OF PEPTIC ULCERATION ON ENDOSCOPY FOR THE DIAGNOSIS OF HELICOBACTER IN A GENERAL POPULATION

doi:10.1136/gutjnl-2013-304907.625

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Introduction Helicobacter Pylori (H. Pylori) is a gramme negative bacillus. It is strongly associated with peptic ulcer disease and gastric cancer. 50% of the population aged over 50 may be infected with H. Pylori. The prevalence in 2008 was 30–40% in the UK adult population with pockets of higher prevalence associated with deprivation. Different diagnostic tests including ^{13}C urea breath test, stool antigen test, serum antibodies to H. pylori and rapid urease (CLO) test are commonly used in current medical practise. Histological detection of H. Pylori in gastric biopsy specimens still remains the gold standard investigation for diagnostic purposes. Our study was to assess whether peptic ulceration at endoscopy should be used to determine Helicobacter testing or whether all patient referred for Gastroscopy with ' non-reflux dyspepsia' should be offered testing.

Methods It was a retrospective observational study analysing results of consecutive 172 patients who had CLO test performed (male 89, female 83) on a single user operator endoscopy list over a 4 months period (March to June 2010). CLO testing was carried out on the discretion of the endoscopist on any patient with unexplained 'dyspepsia' or endoscopic findings of peptic ulceration. Data on whether patients were on a proton pump inhibitor at the time of the endoscopy or concurrent use of non-steroidal anti-inflammatory drugs (NSAIDS) was not recorded.

Results Out of 172 cases, 34 cases were tested CLO positive (12/34 CLO positive patients had evidence of peptic ulcer disease on OGD).138 cases were tested CLO negative of which 62/138 had evidence of peptic ulcer disease. Prevalence figure in our study matched with national UK figures i.e 43.02% (95% CI: 35.51% to 50.78%).

Conclusion Approximately 1/3 of patients found to be CLO positive had signs of peptic ulceration (35%). In the same cohort of patients nearly ½ of patients found to be CLO negative also had signs of peptic ulceration (45%). In our study using evidence of peptic ulceration (gastritis, duodenitis, gastric and duodenal erosions/ulcers) as a guide as to whether a CLO test should be carried out is unhelpful. Caution has to be taken as we did not take into account data as to usage of PPI or NSAIDS. We suggest that presence of endoscopic findings should not be a sole determinant for Helicobacter testing.

Disclosure of Interest None Declared.

PTH-139 A UNIQUE COMBINED GASTROENTEROLOGY/RHEUMATOLOGY CLINIC: THE FIRST YEAR

doi:10.1136/gutjnl-2013-304907.626

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Introduction Articular problems affect many patients with inflammatory bowel disease (IBD) and joint symptoms are often difficult to control despite the therapeutic strategies aimed at controlling gut inflammation (1). Patients with inflammatory rheumatic conditions present a range of clinical problems to the gastroenterologist such as IBD, dysmotility, dysbiosis, liver dysfunction, nutritional problems and drug side effects. Patients often drift between the two specialties with inefficient communication and subsequent delay in a joined up approach to management. We therefore developed a joint gastroenterology/rheumatology clinic to improve the care of these complex patients and now report our experience of the first year.

Methods The clinic is run by a consultant gastroenterologist (GC) and consultant rheumatologist (TL) and attended by both GI and rheumatology trainees, nurse practitioners and medical students. Patients are referred from the respective specialties by consultant or SpR grade physicians. Each patient is given a 30 minute time slot which allows time for assessment, discussion, treatment planning and any therapeutic intervention such as joint aspiration/injection. Most patients are referred back to the individual specialty clinics but where necessary follow up is continued in the combined clinic. All patients attending the clinic are invited to complete a satisfaction questionnaire and give written feedback.

Results We present our experience of the first year of this innovative clinic detailing the wide range of clinical problems encountered together with anonymous patient feedback. We also present trainee, nurse and consultant perspectives on the value of the combined clinic.

Conclusion Although there are many well established combined specialty clinics we believe this is the first report of a combined gastroenterology/rheumatology clinic. The patient feedback has been very positive with all patients finding the clinic of benefit. There are many other advantages including efficiency of patient management, reducing multiple attendances to specialty clinics, learning from each other and teaching of trainees and students.

Disclosure of Interest None Declared.

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PTH-140 RISK STRATIFICATION OF UPPER GASTROINTESTINAL BLEEDING WITH THE GLASGLOW-BLATCHFORD SCORE: EXPERIENCE OF A DISTRICT GENERAL HOSPITAL IN EAST LONDON, UNITED KINGDOM

doi:10.1136/gutjnl-2013-304907.627

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Introduction The Glasgow-Blatchford Score (GBS) is a risk stratification tool to assess the need for clinical intervention to prevent death in patients with suspected upper gastrointestinal (UGI) bleeding[1]. In the UK it has been validated in four centres, with 99.6% sensitivity for not requiring endoscopic or transfusion therapy in patients with a GBS of zero[1,3]. Latest NICE guidelines recommend the GBS for risk stratification in UGI bleeds[2]. We aimed to establish whether the East London population behaved in a similar fashion to published data.

Methods The GBS was calculated retrospectively from audit data collected from patients with suspected UGI bleeding seen by the emergency department (ED) at Whipps Cross University Hospital, London between November and December 2011. During this period, clinical notes for patients with emergency department attendances coded as haematemesis, coffee-ground vomiting and/or melaena were analysed. Patients who were subsequently found to have a different diagnosis were excluded from further analysis. In addition to basic demographic and admission data, we assessed how frequently the GBS was applied. GBS scores were then correlated with endoscopy findings, and the need for endoscopic therapy at the time of endoscopy, and the need for transfusion.

Results 97 sets of notes were identified and 42 patients included in the audit, age range 26–96 (median 66 years). 61% of patients were male and 57% of admissions occurred between the hours of 0900 to 1700. In 77% of patients a GBS was not considered by emergency and/or acute medical physicians. All patients with a GBS of 0 were admitted and subsequently discharged with outpatient endoscopy.

Abstract PTH-140 Table 1

GBS	No. of Patients	UGI Pathology	Endoscopic Therapy	Blood Transfusions
0	5 (12%)	0	0	0
1–5	22 (52%)	3	0	2
6–13	15 (36%)	7	5	13

Of patients scoring 1 to 5, 11% had UGI pathology, 9% (2 patients both GBS of 5) required transfusion only. In patients scoring 6 to 13, 47% of them had UGI pathology, 33% and 87% required endoscopic therapy and blood transfusions respectively.

Conclusion UGI bleeds were most commonly found in males over the age of 65. Locally, the GBS is an underused risk stratification tool in determining the need for admission. Our preliminary data suggests patients with GBS of 0 can be discharged with outpatient endoscopy, and patients with a GBS more than 6 represent a high risk population requring emergent endoscopy. We propose that patients with a GBS of 1 or 2 can also be managed as an outpatient as our data suggest that patients in this group do not require admission. Local data suggests this can reduce patient admission rates by up to 17%.

Disclosure of Interest None Declared.

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PTH-141 COULD UPPER GI CANCER EXPLAIN FALSE POSITIVE FAECAL OCCULT BLOOD TEST (FOBT) RESULTS IN THE BOWEL CANCER SCREENING PROGRAMME?

doi:10.1136/gutjnl-2013-304907.628

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Introduction The Bowel Cancer Screening Programme (BCSP) commenced in England in 2006 using the Hemoccult guaiac faecal occult blood test (FOBt). The study aimed to evaluate if significant numbers of upper GI cancers were being diagnosed in patients with a positive FOBt in the absence of colonic pathology.

Methods A quantitative data analysis of all BCSP patients with a negative colonoscopy cross referenced with all patients within screening age (60yrs >) diagnosed with upper GI cancer in the North East of England, comprising of South of Tyne, North of Tyne, Teesside, Durham and Darlington.

Results Collectively the North East Bowel Cancer Screening centres carried out 5176 colonoscopies from 2008–2011, resulting in 1108 (21.4%) normal investigations.

In the same time period 589 patients were diagnosed with upper GI cancer. 243 were invited to participate in BCSP and 109 (45%) took part. 33/109 (30%) patients were diagnosed with upper GI cancer prior to submitting FOBt, leaving 76 (70%) presumably undiagnosed.

72/76 (94.8%) returned a negative FOBt, 2 (2.6%) returned an unclear subsequently followed by 2 negative FOBt kits according to BCSP practise, leaving 2 (2.6%) patients with a positive FOBt who subsequently had a normal colonoscopy. At the time of screening both patients were symptomatic with upper GI symptoms, and diagnosed with upper GI cancer within 3 months of screening.

Conclusion These data suggest that carrying out an upper GI investigation in FOBt positive and colonoscopy negative patients is not justified. Consideration to investigate maybe given in the