

ranked 2nd (17.3%). Remaining categories fall within medical specialties (e.g. general neurology, cardiology, respiratory) with only 3.9% of admissions attributable to surgical conditions or trauma. Shortest mean LOS were Poisoning/Psychiatry admissions (1.97 days). Greatest single contributor to total bed days was Hepatology at 240,576 per year and (excluding cancer) this had highest inpatient mortality (18.2%).

**Conclusion** 3% of emergency admissions to English hospitals were for ARCs and the majority (95.7%) of admissions fall within the remit of physicians rather than surgeons. Half the recorded diagnoses for admitted patients are within the sub-specialties of hepatology or gastroenterology and these contribute the highest share of both bed days and mortality. This system of classifying hospital data provides a basis for re-design of services, manpower planning and potential metrics for performance.

**Disclosure of Interest** None Declared.

#### REFERENCE

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#### PTH-176 AUDIT TO EVALUATE THE GASTROENTEROLOGY REGISTRAR OF THE WEEK SERVICE IN UNIVERSITY HOSPITALS OF LEICESTER

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<sup>1,2</sup>V M Gordon, <sup>1</sup>D Rogers, <sup>1</sup>P Hooper. *Gastroenterology, University Hospitals Leicester, Leicester, UK*

**Introduction** The 'Registrar of the Week' service initially started in response to a Primary Care Trust initiative for Gastroenterology advice to GP's. This started as project 'Batphone'. The Gastroenterology department saw an ideal opportunity to start a Gastroenterology phone advice service which would be manned by an allocated Gastroenterology Registrar of the week, running Monday to Friday, 9–5pm excluding bank holidays. This started in August 2011. We give advice and see patients within the Leicester Royal Infirmary (LRI) as well as give advice to GP's and across site at the Leicester General Hospital (LGH) and Glenfield General Hospital (GGH).

**Methods** We collected data using a designed proforma to document all calls including origin, date time and also a summary sheet for the day. 262 days documentation was reviewed as these were complete. These were analysed.

**Results** The number of calls in 262 days was 2652. The range was 1–36 calls per day, but on average 10 per day. 512 patients were identified for a Gastroenterology ward. There were 607 patients physically reviewed. 1870 calls came from the LRI, 165 from LGH, 195 from GGH and 276 GP calls. This works out roughly 1 call per day from each of the latter.

**Conclusion** We have seen a great increase in the usage of our service. We think that the audit data may well be an under reflection of the work done as people forget to fill the sheets in. The intensity is unpredictable. The number of GP calls is far lower than the number of hospital calls. It was felt overall the service was being avidly utilised by mainly medical and surgical teams and that it was also good experience for our Gastroenterology specialist Registrars.

There were misuses of the telephone for example patients and relatives being put through. We are hoping to reduce this by education and circulation of further guidelines. The things we intend to change are the actual telephone as the reception is poor. Referrals that need to be seen the same day should be referred before 12pm. Guidelines for referral will be circulated. There will be more formalised consultant back-up in the future. We believe our service has been a success especially in the sense that we are able to know about and manage patients earlier although we think the efficiency of the service could be improved. We intend on re-auditing this service in the future so that we can continually improve it.

**Disclosure of Interest** None Declared.

#### PTH-177 A NEW PANCREATOBILIARY TELEPHONE CLINIC SERVICE – IMPROVED SERVICE DELIVERY, EFFICIENCY AND PATIENT EXPERIENCE

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<sup>1,2</sup>V Sehgal, <sup>1</sup>B Krishnan, <sup>1</sup>M Kumar, <sup>1</sup>M H Chapman, <sup>1</sup>S P Pereira, <sup>1</sup>G J Webster, <sup>1</sup>G J Johnson. *Pancreatobiliary Medicine, University College Hospital, London, UK*

**Introduction** Following the establishment of specialist cancer centres (and other centralised services), increasing numbers of patients are referred for tertiary care. This may have implications for travel, particularly as patients now have to pay travel costs. As a tertiary referral centre for pancreaticobiliary (PB) medicine we are referred patients from across the UK for a specialist opinion on complex benign and malignant PB problems. The established system of an initial face-to-face clinic visit often then requires return visits for investigations or endoscopic intervention, with significant inconvenience and travel costs for the patient. In response to this, we developed a novel, consultant-led telephone clinic (TC) service. The aims of this service were to improve efficiency and patient satisfaction.

**Methods** A TC service was commenced with prospective data entry into a database over a 12-week period. Data was obtained on the following: patient demographics; postcode; clinical indication; round distances patients would have otherwise travelled if visiting UCLH. The time and cost incurred for visiting UCLH was calculated using the cheapest return train fare to London Euston (nearest train station). Patients were contacted some time after their consultation by an uninvolved member of non-clinical staff to obtain feedback based on a 9-point questionnaire.

**Results** 77 patients were listed for consultation in 10 separate TC's. 17 (22%) were excluded (9 did not answer their original TC; 8 did not answer for feedback). Of the 60 patients analysed (35 female, median age 52.5 years), 12 (20%) were new referrals and 48 (80%) follow-ups. The average round distance if otherwise travelling to UCLH was 96 (3–606) miles. The average time and cost for a return trip to UCLH was 155 (8–593) minutes and £27.60 (£7.30–105). Clinical indications were suspected Sphincter of Oddi dysfunction 18 (30%); acute or chronic pancreatitis 12 (20%); cholangiopathy 6 (10%); choledocholithiasis 5 (8%); non-PB gastrointestinal disease 9 (15%). 14 (23%) had formal out patient clinic review following their TC consultation. In 22 (37%) a repeat TC appointment was sufficient and 7 (12%) were discharged. The remaining 17 (28%) were referred for further endoscopic or radiological imaging at UCLH with TC follow up afterwards. All 60 patients either 'strongly agreed' (52, 86%) or 'agreed' (8, 13%) that the TC service was efficient. 29 (48%) expressed concerns regarding travel costs if visiting UCLH. Only 4 (6.7%) would have preferred to have seen a doctor in person for their initial consultation.

**Conclusion** We have demonstrated that a TC service is a useful adjunct in helping to deliver an efficient and convenient tertiary PB service, with excellent patient satisfaction.

**Disclosure of Interest** None Declared.

#### PTH-178 WHO CALLS THE LIVER REGISTRAR AT KING'S?

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<sup>1,2</sup>W Alazawi, <sup>1</sup>K Agarwal, <sup>1</sup>A Suddle, <sup>1</sup>V Aluvihare, <sup>1</sup>M Heneghan. *Institute of Liver Studies, King's College Hospital; <sup>2</sup>The Blizzard Institute, Queen Mary, University of London, London, UK*

**Introduction** Delivering excellent healthcare in today's NHS involves multiple agencies and depends on accurate communication between professionals in different locations. King's College Hospital is a leading Hepatology centre that receives tertiary and quaternary referrals from across the UK and Europe. Frequently, the first point of contact with the Unit is via a telephone call to a Specialist Registrar, for whom no case notes are available in which to record information. Until recently,

referrals were recorded on paper and filed in a secure office in the Department. We introduced an electronic database system to record a standardised dataset from each call in order to improve clinical governance and to generate contemporaneous records that could be easily retrieved and audited. We present our five-month pilot data.

**Methods** A Caldicott-compliant database was designed and made securely available to Registrars and Consultants. Registrars were encouraged to record all referrals and telephone calls they received. Calls taken by the Liver Intensive Care Unit, consultants, nurses, junior doctors and the out of hours team were excluded. Demographic and clinical data were recorded in real time with information regarding the source of the referral and the outcome of the call. There were no mandatory fields.

**Results** Data from 350 calls were entered over five months. The source of the call was recorded in 345 cases. 125 (36%) were from King's College Hospital and 20 (6%) were from General Practitioners or patients. The remaining 200 calls came from 75 institutions. Of the 220 calls made from outside the Trust, 63 resulted in the patient being transferred ( $n = 32$ ), reviewed as an out-patient ( $n = 27$ ) or discussed at a multidisciplinary team meeting ( $n = 4$ ) at King's.

In 235 cases, discussion with a King's Consultant was recorded (67%). Of the 115 calls where discussion with a Consultant was not recorded, 41 were from within King's, 19 were transferred to King's and in 36 cases there was continuing input by telephone advice from one of the teams at King's. Only 15 extramural cases (7.5%) were concluded without a documented discussion with a Consultant.

**Conclusion** Use of an electronic database to record extramural telephone advice given by senior trainees and Consultants provides clinical governance to this service and forms a contemporaneous record that is kept at the referral centre. The data can be used to estimate workload and to determine the disease burden in this population, thereby tailoring services to the needs of referrers and commissioners. Formal recording of the Consultant input in the advice service also forms an excellent training opportunity for trainees. We recommend the implementation of similar databases in other units that give verbal advice to colleagues outside their own institution.

**Disclosure of Interest** None Declared.

## Small bowel

### PTH-179 AN AUDIT OF CLINICAL OUTCOMES OF SEHCAT STUDY IN PATIENTS WITH CHRONIC DIARRHOEA

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<sup>1</sup>L Kumar, <sup>2</sup>B Jamshed, <sup>1</sup>A Emmanuel. <sup>1</sup>Gastroenterology; <sup>2</sup>Nuclear Medicine, UCLH, London, UK

**Introduction** Latest NICE guidance suggest that there is not enough evidence to determine whether SeHCAT test is a cost effective option for diagnosing bile acid malabsorption (BAM) among people with IBS-D and Crohn's disease patients without ileal resection. We undertook an audit of sequential patients referred for SeHCAT testing to assess diagnostic value.

**Methods** Retrospective data was collected from 88 consecutive patients referred to Nuclear Medicine for SeHCAT testing over one year. The indication for the test request and treatment given were collected from request forms, clinic letters and GP record. Subjective global outcome was assessed at mean of 3 months after treatment (range 2–7).

**Results** Of 88 patients who underwent SeHCAT test, 49 (56%) were found to be positive for bile acid malabsorption. Of these 29 (59%) had severe (< 5% retention), 9 (18%) had moderate (> 5 and < 10% retention) and 11 (22%) had mild BAM (> 10 and < 15% retention).

With regard to the distribution of positive SeHCAT test results according to aetiology, there were 18 patients who fell into BAM Type

1 (Ileal disease/resection) group out of which 17(94%) were positive. Type 2 (Idiopathic BAM) had a total of 57 patients out of which 24(42%) were positive and Type 3 (Secondary to other GI disease) had 13 patients of which 8(62%) tested positive to SeHCAT study.

Table 1 below shows the outcomes of bile acid sequestrant (BAS) according to BAM groups.

**Abstract PTH-179 Table 1**

BAM type	Treatment	Outcome mean 3 months	
Type 1 (n = 17)	Started (12), dose increased (3), same dose (2)	Better 12	No change 3 Drug not tolerated 2
Type 2 (n = 24)	Started (16), dose increased (2), same dose (5), declined (1)	Better 11	No change 7 Drug not tolerated 6
Type 3 (n = 8)	Started (7), dose increased (1)	Better 4	No change 2 Drug not tolerated 2

39/88 (44%) patients had a negative test. Diagnoses were made as follows: IBS-D 13, inflammatory bowel disease with no BAM 8, functional or non-specific diarrhoea 18. In these patients BAS was empirically started, in spite of the test results, in 6, 2 and 5 patients respectively. Only 1 of these 13 (8%) patients (who had IBS-D) improved.

**Conclusion** Changes in treatment as a result of the SeHCAT test were made in 70% (62/88) of all patients: 84% (41/49) positive patients and 33% (13/39) negative patients. In terms of yield of SeHCAT, patients with chronic diarrhoea and ileal disease (BAM Type 1) may warrant empiric BAS treatment without testing since there was 94% response, suggesting limited value in terms of yield of new information. In contrast, there was value to a negative study, which predicted lack of response (8%) to BAS.

**Disclosure of Interest** None Declared.

### PTH-180 SMALL BOWEL ULTRASOUND AND VIDEO CAPSULE ENDOSCOPY: COMPLIMENTARY INVESTIGATIONS TO DIAGNOSE SMALL BOWEL CROHN'S DISEASE

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<sup>1</sup>M J McDonnell, <sup>2</sup>R Beable, <sup>2</sup>A Higginson, <sup>1</sup>M A Quine, <sup>1</sup>D S Pearl. <sup>1</sup>Department of Gastroenterology; <sup>2</sup>Diagnostic Imaging Department, Portsmouth Hospitals NHS Trust, Portsmouth, UK

**Introduction** Crohn's disease affecting the small intestine requires accurate localization, assessment and follow up, to direct and monitor therapy. Video capsule endoscopy (VCE) has an established role in small bowel Crohn's evaluation; however, use is limited by procedure costs and risks of capsule retention. Small bowel ultrasound (SB USS) with doppler is a rapid, inexpensive, dynamic and non-invasive method for assessing activity of Crohn's disease. We present the largest published comparative UK dataset of SB USS and capsule endoscopy in Crohn's disease.

**Methods** A 5 year retrospective analysis from 2008–2012 was carried out. Patients investigated for suspected small bowel Crohn's disease with SB USS and VCE were included, if one examination occurred within 12 month of the others. VCE findings were graded as mild (apthous ulcers only), moderate (apthous ulcers with mucosal distortion) or severe (apthous ulcers with mucosal distortion and strictures/stenosis). SB USS was graded positive or negative for small bowel Crohn's disease. Both assessments were single operator. Results were expressed as sensitivity, specificity, positive and negative predictive value (PPV and NPV) of SB USS compared with VCE for detection of small bowel Crohn's. Sub-analysis of SB USS findings for VCE-defined severity of small bowel Crohn's disease was carried out.

**Results** 500 VCE procedures were reviewed, of which 61 fulfilled the inclusion criteria. 19 patients had SB Crohn's on VCE; this was detected in 5 patients by SB USS (sensitivity 26%). 42 patients had no evidence of SB Crohn's on VCE; none of these had SB USS findings (specificity 100%). 56 patients had a negative SB USS, of these