the planned surveillance date, either due to inadequate biopsies being taken to delay/discharge or appropriate date of surveillance already booked. 15/125 (12%) patients were either discharged or had their OGD delayed. If all procedures had been compliant with BSG standards this might have led to more than three times as many patients having their surveillance discontinued or delayed (48/125:38%).

Conclusion Using the 2013 BSG guidelines enables departments to safely discharge patients with Barrett's oesophagus or increase surveillance intervals. This will save money and reduce the risk and discomfort inherent with this program. Endoscopists adherence to the Seattle biopsy protocol is poor, and this is the main barrier preventing more patients from being discharged.

REFERENCES

1 Coleman HG, *et al*. Increasing incidence of Barrett's oesophagus: a population-based study. *Eur J Epidemiol* 2011;26(9):739–45
2 Abrams JA, *et al*. Adherence to biopsy guidelines for Barrett's esophagus surveillance in community setting in the USA. *Clin Gastroenterol Hepatol* 2009;7 (7):736–42
3 Fitzgerald RC, *et al*. British Society of Gastroenterology guidelines on the diagnosis and management of Barrett's oesophagus. *Gut* 2014;63:7-42

Disclosure of Interest None Declared.

PTH-038 ALBUMIN AS A PLASMA EXPANDER DURING LARGE VOLUME PARACENTESIS: ARE WE FOLLOWING THE GUIDELINES?

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Introduction Ascites is a major complication of cirrhosis occurring in more than 50% of patients within 10 years. Tense ascites is treated with large volume paracentesis (LVP) with human albumin solution (HAS) as a plasma expander. National and International guidelines recommend that cirrhotic patients undergoing LVP (>5 l) should have 8 g of HAS per litre of ascites drained. This equates to 1 unit of 20% HAS per 2.5 l of ascites drained. HAS is not recommended for non-cirrhotic ascites or small volume paracentesis (SVP), where <5 l of ascites is drained. Our aim was to see if local practice followed guidelines.

Methods We conducted an audit of all paracenteses occurring in a London district general hospital between January 2012 and October 2013. We included day unit patients and inpatients undergoing paracentesis. We reviewed medical notes, prescription charts and nursing records, including cases with suitable documentation.

Results Sixteen patients had a total of 48 drainage episodes between them, of which 9 were male and median age was 71 years (range 45–93 years). Eleven patients had cirrhosis and 5 had non-hepatic malignancy. Table 1 demonstrates that there were 36 paracentesis episodes in cirrhotic patients where LVP was carried out with a median of 4 units of HAS given per drainage. On the other 12 occasions HAS did not need to be given. In 20/36 cases at least 2.5 l of ascites was drained for each unit of HAS given. In the 16 other cases of LVP in the cirrhotic patients, HAS was overprescribed with a total of 19 units being given unnecessarily in this group.

In total 25 units of HAS were given to patients undergoing small-volume paracentesis and those with malignant ascites. The cost per unit of HAS is £29, thus potentially £1276 could have been saved if guidelines had been followed. There were no complications associated with drain insertion nor was there any hypotension, acute kidney injury, or electrolyte disturbance related to HAS infusion.

Conclusion Albumin is often inappropriately prescribed to patients with malignant ascites and those undergoing small volume paracentesis. Of the paraceteses where HAS was indicated, 16/36 (44%) were overprescribed albumin. This has unnecessary cost implications as well as potential health risks due to the hyperoncotic properties of HAS. We conclude that reducing HAS usage by following guidelines during LVP would reduce costs without compromising patient safety.

REFERENCE

Runyon B Management of Adult Patients with Ascites due to Cirrhosis: An Update. AASLD Practice Guidelines, 2012.

Disclosure of Interest None Declared.

PTH-039 PREVENTING POST-ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP) PANCREATITIS: CHANGING PRACTICE AT A DISTRICT GENERAL HOSPITAL

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Introduction Post-ERCP pancreatitis (PEP) is one of the major endoscopic complications carrying 3.5% risk in unselected patients. Daycase ERCP is now the norm in the UK and emergency presentations with PEP may be expected. At Basildon Hospital, we sought to adopt ESGE guidelines (2010)[1] to prevent PEP with regards to: serum amylase testing, rectal non-steroidal anti-inflammatory (NSAID) and pancreatic duct (PD) stent use. Since March 2013, a protocol incorporating these recommendations was followed.

Methods A prospective audit between December 2012 to 2013 was performed to evaluate the effect of this management protocol. Data was collected on an audit proforma completed immediately following ERCP. Patient outcome was followed up via telephone on subsequent day or review of inpatient notes. Electronic records were searched for admissions within 2 weeks of ERCP.

Results 249 ERCP procedures were recorded over the 12 month period. 41% were male; 45% were performed as outpatient. Mean age was 68 years. Main indication was gallstones (60%).

Abstract PTH-038 Table 1

Cause of Ascites	Type of drainage	Number of drains	Median amount (Range) of ascites drained (L)	Median amount (Range) of HAS given (units)
Cirrhosis	LVP	36	9.9 (5.5–16.5)	4 (3–9)
	SVP	4	2.4 (1.2–4.45)	1.5 (1–3)
Malignant ascites	LVP	5	7.2 (5.0–8.0)	3 (3–5)
	SVP	3	3.8 (1.5–4.4)	0

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Abstract PTH-039 Table 1 Summary of complications

	Before protocol	After protocol				
	Number (%)	NSAID (102)	no NSAID (62)	PD stent (17)	no PD stent (163)	Number (%)
Pancreatitis	2/67 (3)	5	0	1	5	6/180 (3)
Perforation	0/67 (0)	1	0	0	3	3/180 (1.5)
Bleeding	2/67 (3)	2	0	0	3	3/180 (1.5)
Admission	7/67 (10)	10	1	1	10	11/180 (6)

224 amylase tests were performed on 139 patients. 27/139 patients had abnormal amylase (>1.5x upper limit normal (ULN) at 2–4 h or 3–5x ULN at 4–6 h). 14 were asymptomatic, 3 patients were admitted. Remainder with mildly abnormal amylase were managed without admission after clinical assessment.

There were total 8 cases of pancreatitis (3.2%), all associated with significantly raised amylase, apart from one (inpatient) case with a late rise at 48 h. Pre-protocol, 1 patient developed pancreatitis after discharge from day case.

NSAID use rose from 0 to 57% (14% contraindications), with no increased bleeding associated. PD stent insertion rose but remained infrequent, limited by technical feasibility. Pancreatitis rates did not significantly differ with prophylactic measures.

Conclusion This audit demonstrated the real-life practice of ESGE guidelines to assess for and reduce ERCP-related complications. Amylase measurement was feasible – raised levels correlated with PEP but 1 case had normal early amylase. The few admissions with asymptomatic raised amylase is offset by avoiding emergency admission with PEP. In this small study NSAID and PD stent did not improve complication rates and remain under-utilised, but likely will increase as experience grows.

REFERENCE

1 Dumonceau JM *et al*. European Society of Gastrointestinal Endoscopy (ESGE) guideline: prophylaxis of post-ERCP pancreatitis. *Endsocopy* 2010;42:503-515

Disclosure of Interest None Declared.

PTH-040 USING NICE CRITERIA TO ASSESS THE MANAGEMENT OF ACUTE UPPER GI BLEEDS DURING WEEKENDS – THE EXPERIENCE OF A DISTRICT GENERAL HOSPITAL

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Introduction The management of acute upper GI bleeds (AUGIB) comes under greatest stress at weekends; this is a topical concern given the national drive towards a 7 day working week. We previously described the development of a centralised cross-county out of hours endoscopy service.[1] We aim to critically appraise this service against NICE guidelines (CG141) and quality standards (QS38) for the management of AUGIB.

Methods Our computer-based endoscopy database was retrospectively analysed to identify patients undergoing gastroscopy (OGD) for AUGIB during the weekend in 2012. Full demographic information and OGD reports were identified in all 95 cases; complete patient records were located for 66 (69%) patients.

Results The average patient age was 71. 66% were new episodes of AUGIB: the rest had AUGIB during admission with different pathology. 11% (10) of patients did not survive their admission. 81% (76/95) had significant diagnoses on OGD. Of note, 38% (36) of patients had peptic ulcer disease, 8% (7) had cancer and 5% (4) had varices.

While 86% (57/66) of patients received a pre-endoscopy Rockall score, 11% had full Rockall scores, and only 3% had a Blatchford score documented. 55% (37) of patients underwent transfusion; half were overtransfused to a Hb >10 g/dL. Correction of coagulopathy was adequate in 4 of 6 patients. Platelet and recombinant factor VII use was in keeping with NICE guidance. 36% of patients inappropriately received intravenous PPI prior to OGD. Only 1 of 5 patients with suspected variceal bleeding received antibiotics and terlipressin at presentation.

6% (4/66) of patients remained haemodynamically unstable despite resuscitation – all had OGDs within four hours of admission. 88 and 95% of patients underwent OGDs within 24 and 48 h of admission respectively. The main reasons for delays were lags in submitting OGD request forms and inadequate fasting, rather than a lack of endoscopy capacity. All patients received appropriate endoscopic therapy modalities, and timely repeat OGDs or surgical intervention when warranted. All patients on aspirin for secondary prevention of vascular events were recommenced on aspirin when haemostasis was safely achieved.

Conclusion The trust provides a comprehensive out of hours endoscopy service, particularly for emergency cases with persisting haemodynamic instability. There remains scope for further improvement in pre- and post-endoscopy care. This exercise highlights the use of NICE-generated standards in guiding service development, and can be replicated in most district general hospitals.

REFERENCE

1 ShokouhiBN *et al*. The setting up and running of a cross-county out-of-hours gastrointestinal bleed service: a possible blueprint for the future. *Frontline Gastroenterol* 2013;4:3 227–231

Disclosure of Interest None Declared.

PTH-041 A HIGH QUALITY TRANSIENT ELASTOGRAPHY SERVICE CAN SUCCESSFULLY BE DELIVERED BY HEALTHCARE ASSISTANTS

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Introduction Surrogate assessment of liver fibrosis by means of liver stiffness measurement (LSM) by transient elastography is well validated in different cohorts of patients with liver disease and is now a part of routine hepatological practice. There is an increasing demand for LSM in view of its role in managing patients with dermatological or haematological conditions who are on potentially fibrogenic therapy. Referrals for LSM in our unit have increased significantly over the last 12 months. Traditionally, specialist liver nurses have been trained to deliver this service. However, LSM by transient elastography is an easily transferable skill and therefore in a bid to reduce waiting times and make the service as cost effective as possible, we trained

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