

nutrition is more physiological and less expensive than IV feeding but requires close clinical and biochemical monitoring in patients with metabolic instability usually only possible during in-patient stay.

In 2006, PHT Nutrition Support Team introduced a 'virtual ward' outpatient model to facilitate home discharge of metabolically unstable IF patients requiring nutritional support until planned revision surgery or on a long term basis.

**Methods** Twenty consecutive patients were identified and audited using a database of referrals to the nutrition team, from January 2009 to July 2010 for post-operative complications requiring nutritional support (excluding post-operative ileus). Information was collected on patient demographics, aetiology and anatomy of bowel dysfunction, and methods of nutritional support. Outcomes included re-admission days and time to definitive surgery.

**Results** The audited population were 11 females, 9 males, aged 27-75yrs, with an aetiology of intestinal infarction (5), IBD (3), malignancy (7) and other (5); and resulting in high end stoma (1), jejunostomy with accessible distal bowel (8) and enterocutaneous fistulae (2), 15 had had intra-abdominal sepsis. All had reduced proximal small bowel length (23-230cm; mean 129cm), metabolic instability with fluid/electrolyte depletion on oral intake (despite medical management), and high stoma or fistula output (>2l/d). 13/20 patients were for planned definitive surgery (6 completed). Mean inpatient time to discharge was 57 days.

14 patients were managed successfully as outpatients using enteral support (nasogastric (NG) or mucous fistula) with salt supplementation. 3 patients declined NG tubes but were maintained on oral rehydration solution (>= 1l/d) (one with continued electrolyte depletion). 3 patients required TPN (multiple enterocutaneous fistulae (1) and failed mucous fistula feeding (2)).

During the audit period 18 patients were discharged home for a total of 2731 days (mean 151 days). Re-admission days were 47 (excluding admissions for revision surgery) (2.1% of total days post-discharge).

There were no recorded cases of MRSA.

**Conclusion** Our audit suggests that post-operative intestinal failure was commonly associated with short bowel due to high small bowel stomas or enterocutaneous fistulas. This could be commonly managed through enteral support. A small number were maintained on oral rehydration fluids or required TPN.

**Competing interests** None.

**Keywords** Intestinal Failure, nutrition support.

PTU-075 **AUDIT OF ENTERAL AND PARENTERAL MANAGEMENT IN POST-OPERATIVE INTESTINAL FAILURE IN A DISTRICT GENERAL HOSPITAL**

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**Introduction** Managing prolonged post-operative intestinal failure is complex and resource intense. Frequently, fluid, electrolyte and nutritional needs necessitate in-patient IV support or, if metabolically stable, home parenteral nutrition. Enteral