jejunostomy. Her enteral feed was changed from elemental to modular on day 8 and sandostatin commenced. Her nutritional markers improved on this regime and despite having only 50 cm of jejunum proximal to her stoma, outputs were low and her electrolytes remained normal. She put on weight post-operatively and proceded to closure of her stomas at 6 months.

Results N/A.

Conclusion Discussion: Internal hernias are rare and commonly present with small bowel obstruction. Paraduodenal hernias are the most common form and can be either left or right sided. Normal small intestinal length varies between about 275 cm to 850 cm with nutritional or fluid supplementation required for patients with <200 cm. This lady had a post-operative bowel length of 225 cm. The majority of gastrointestinal secretions are reabsorbed in the upper jejunum and patients with jejunostomies often have large volume stomal output. We used loperamide and codeine to slow intestinal transit, aid absorption and prevent fluid and electrolyte imbalance. Limited reports of bile-jejunostomy recycling were found in the literature and to our knowledge no cases have been reported of patients with short bowel being managed using recirculation of jejunal effluent and enteral nutrition in isolation. In this case, jejunostomy fluid was collected and immediately recycled via a feeding ileostomy eliminating the need for parenteral nutrition. Success was shown by improvement in nutritional status and weight gain.

Conclusion This case exemplifies the effective use of jejunostomy output recycling to reduce water and electrolyte loss and aid fat absorption in a patient with short gut thus preventing the use of parenteral nutrition.

Competing interests None declared.

PMO-074 A 10 YEAR RETROSPECTIVE REVIEW OF NASOGASTRIC TUBE USE IN A DISTRICT GENERAL HOSPITAL

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Introduction A Nasogastric tube (NGT) is a commonly used device for administration of enteral feeding. It may be used as a bridge to a more definitive procedure (eg, Percutaneous Endoscopic Gastrostomy; PEG) or until patient recovery. The NPSA estimates that *"thousands of NGT are placed each day"* throughout the UK.[1] However, following a literature review we were unable to find any outcome data for this procedure.

Methods We performed a retrospective review of our nutrition database at Basildon and Thurrock University Hospitals NHS Foundation Trust, that serves a population of 375 000, for all patients who had an NGT inserted between years 2001 and 2011 and analysed the insertion reason and outcome.

Results Over a 10-year period, 2526 patients underwent 2715 episodes of NGT insertions, with a male to female ratio of 49.5% and 50.5%, respectively. The total number of feeding days was 50 584, with a median and mean length of insertion of 10 and 18.7 days, respectively. 189 patients required a repeat NG feeding episode, either within the same or subsequent hospital admission. The referral reasons and outcome data are shown in the Abstract PMO-074 table 1 below.

Conclusion Data analysis revealed that two thirds of all NGT insertions were for patients with dysphagia secondary to a neurological condition, mechanical obstruction or artificial ventilation. Despite these patients being unwell and high risk for complications 46.9% were able to restart oral feeding. However, almost an equal number died while receiving NGT enteral feeding. 2.7% of our cohort were discharged home with some form of long term enteral feeding; either via a PEG or longterm NGT.

Competing interests None declared.

REFERENCE

1. Patient safety alert NPSA/2011/PSA002: reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants. 2011. Supporting Information.

PMO-075 30-DAY MORTALITY RISK FACTORS FOR PERCUTANEOUS ENDOSCOPIC AND RADIOLOGICALLY-INSERTED GASTROSTOMY

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Introduction Gastrostomy insertion is of benefit in selected patients,[1] but 30-day mortality is as high as 54% in some patient groups.[2] Risk factors associated with early mortality include advanced dementia, age >75 years, serum albumin <30 g/l, C-reactive protein >10 mg/l, cardiovascular and respiratory comorbidities.[3 4] The Sheffield scoring system has been developed to identify patients at risk of early death.[5] The current study examines risk factors associated with 30-day mortality in a cohort of patients who underwent percutaneous endoscopic gastrostomy (PEG) or radiologically-inserted gastrostomy (RIG) in a district general hospital over a 12-month period.

Methods A retrospective review was made of case notes of all patients who underwent a PEG (n=26) or RIG (n=16) insertion in the period July 2010–July 2011. PEG/RIG re-insertions were excluded. Demographic, clinical and biochemical data were analysed.

Results The main indications for a PEG/RIG insertion were cerebrovascular accident (n=14), chronic neuromuscular disease (n=10), oropharyngeal malignancy (n=8), intracerebral pathology other than stroke (n=6), cognitive impairment (n=2), ICU neuropathy (n=1) and somatisation disorder (n=1). The overall 30-day mortality was 7/42 (16.7%). The main risk factors associated with 30-day mortality were age >75 years ($p<0.05$) and cardiovascular co-morbidities ($p<0.01$). The serum albumin, C-reactive protein and respiratory comorbidities were not associated with early mortality. There was no correlation between 30-day mortality and Sheffield score.

Abstract PMO-074 table 1

Reason for referral	Total episodes	Percentage of total (%)	Outcome of NG feeding	Total episodes	Percentage of total (%)
Dysphagia	1689	62.2	Restart oral feeding	1272	46.9
Malnutrition	635	23.4	Died	1208	44.5
Post operative GI tract	266	9.8	Transferred out of area	157	5.8
Miscellaneous*	69	2.5	Discharged home on enteral feeding	74	2.7
Post operative non GI tract	42	1.5	Self discharged	2	0.1
Increased nutritional requirements	25	0.9	Missing data	2	0.1

*Miscellaneous includes missing data (19 and 0.7); intestinal obstruction (16 and 0.6); intestinal failure (8 and 0.3); malabsorption (4 and 0.2) and NG feed during the course of an episode of acute pancreatitis (22 and 0.8).