PTU-259 STENT PLACEMENT IN PALLIATION OF OESOPHAGO-GASTRIC CANCER: THE STORY SO FAR

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Introduction The majority of patients with oesophago-gastric cancer are diagnosed at an advanced incurable stage where palliation of symptoms remain the cornerstone of management. Most centres now palliate patients endoscopically with stent insertion, argon plasma coagulation and laser therapy.

Methods This is a retrospective review of the overall use of palliative stenting in patients with advanced oesophageal and gastric cancer across 2 acute hospital trusts in Hertfordshire with a catchment population of approximately 1 million in the 1-year period between 1 April 2010 and 31 March 2011. We looked through the endoscopy reports, medical notes and our prospectively maintained Upper Gastrointestinal Cancer database for any reported post procedural complications and calculated the 7, 14 and 30-day mortality rate for this cohort of patients.

Results 30 patients in West Hertfordshire NHS Trust (WHHT) and 19 patients in East & North Hertfordshire NHS Trust (E&NH) had stent insertion where the median age is 76 years. 53% of patients in E&NH were diagnosed with squamous cell carcinoma compared to 20% in WHHT. 53% of all patients stented in WHHT received both intravenous sedation and pharyngeal anaesthesia in comparison to E&NH where 21% had the same combination. The main type of stent deployed is the Boston Scientific Ultraflex covered metal stent, with only 3% of patients receiving an uncovered metal stent. All the stents were deployed successfully. Within 3 months of insertion, stent migration was reported in six patients (12%), all of whom had covered metal stents. None of our patients had perforation or haemorrhage post procedure. Our 14 and 30-day mortality is 7% and 18% respectively which mirrors, if not lower than the national figures of 8% and 19%.

Conclusion The difference in histology between the two trusts reflects additional use of laser therapy in E&NH. The reliability of reporting of complications to the national audit was questioned at the recent British Society of Gastroenterology Meeting 2011. The apparent increase in our complication rates is likely to reflect the more accurate reporting across the region due to the existence of a robust prospectively maintained database. Our patient selection seemed appropriate given that most of them survive for more than 30 days. Uncovered stent or laser therapy should be considered in appropriate patients to reduce stent migration rates. The effectiveness of the procedure can be evaluated with a standardised dysphagia scoring system. Our audit is leading towards a change in stent management across the network.

Competing interests None declared.

PTU-260 ARE WE WORKING AT A LOSS? DOES ROUTINE CODING FOR ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP) PROVIDE ACCURATE REMUNERATION?

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Introduction Endoscopic procedures in the UK are remunerated through "Payment by results" with a healthcare resource group (HRG) tariff assigned to each procedure. HRG tariffs depend on accurate coding of the diagnosis and procedure to enable appropriate payment from primary care trusts (PCT). There is little existing data about the accuracy of coding in ERCP to generate appropriate HRG tariffs.

Methods Cases were randomly selected from those attending for ERCP at our unit between 24 March 2010 and 2 July 2010 with full information available. Each procedure was reviewed by a member of the hospitals coding department and a consultant gastroenterologist who regularly performs ERCP, with details of initial routine coding available. Cases were all re-coded following clinician input with subsequent re-calculation of HRG tariff.

Results 39 cases were reviewed. 20 in-patient procedures and 19-day cases. This included 24 (61.5%) accurately coded and 15 (38.5%, 2-day cases and 7 in-patients) requiring re-coding. The re-coding was due to incorrect primary diagnostic code: 3; primary procedure code: 9; both codes: 3. Four of the procedure code changes resulted in increases to HRG tariffs. None of the re-coding led to a reduction in tariff. Three of these were due to incorrect coding of metal stent insertion and one due to omission of coding for sphincterotomy. The initial coding led to an income of £60 033 with the revised coding suggesting remuneration should have been £69 037: a shortfall of £9004. The single biggest shortfall was in the coding of "stent" insertion. Unless clearly labelled as "metal stent," these were routinely coded as plastic stents which carry a lower tariff.

Conclusion There is a difference in coding of ERCPs in 38.5% of procedures we studied. This led to over 10% re-coded to a higher HRG tariff, potentially increasing ERCP related income. Accurate coding is necessary to ensure appropriate remuneration for hospital trusts. Particular attention to the recording of insertion and coding of metallic stents is needed.

Competing interests None declared.

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PTU-261 ALCOHOL MISUSE: REFER AND DETER. REDUCING RE-ADMISSION RATES FOR INPATIENT DETOXIFICATION

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Introduction Alcohol abuse and related diseases are growing public health concerns. In the UK 26% of adults consume harmful quantities of alcohol.[1] Alcohol related admissions are increasing by 11% each year.[2] Yorkshire and Humber encompass one of the highest rates of alcohol misuse in the UK. NICE have developed a National Alcohol Strategy to target these issues which cost the UK economy £23 billion and NHS >£2.7 billion per year.[3] Despite initiatives to improve the quality of care and improve continuity between primary and secondary care, 58% of UK acute medical units lack an alcohol support service.

Methods We retrospectively audited the impact of the Alcohol specialist nurse (ASN) on readmission for inpatient detoxification between 2004 and 2011 at our hospital. This followed the establishment of an Alcohol Care Team in 2005 as recommended by The British Society of Gastroenterology.[2] Medical and surgical inpatients

were included. Exclusion criteria: outpatient and A&E attendances, telephone consultations.

Results Between 2004 and 2011 the mean inpatient readmission rate for medical detoxification was 26.7% (484 readmissions, 1813 total admissions). On average 22.4% of medical and surgical inpatients were readmitted over the 7-year period (293 readmitted/1512 total admissions). Both the yearly readmission rate and percentage of patients requiring readmission increased by 589% and 689% respectively between 2004 and 2011, peaking in 2008–2009 predominantly due to an increase in patients readmitted once (four patients in 2004–2005 compared to 67 patients in 2008–2009). On average patients were readmitted 2.5 times for detoxification. The average period between readmissions was 9.4 months. 10% of patients were re-admitted for detoxification more than 5 times in this period (mode 6 readmissions, range 6–23 readmissions).

Conclusion Admission rates for inpatient detoxification are high. However, <25% of patients require readmission and only a minority require more than five detoxifications, thereby reflecting the efficacy of the ASN and Alcohol Care Team in minimising revolving door patients and the economic cost incurred. We recommend that all general hospitals should offer this service to effectively manage alcohol misuse.

Abstract PTU-261 Table 1

	% Patients readmitted (absolute value/total patients)	% Readmissions (absolute value/total admissions)
Year		
April 2004–March 2005	3.9 (6/154)	4.6 (8/174)
2005–2006	19.5 (32/267)	15.4 (52/337)
2006–2007	14.2 (22/155)	20.3 (40/197)
2007–2008	19.0 (33/174)	22.7 (51/225)
2008–2009	40.6 (89/219)	43.1 (132/307)
2009–2010	17.8 (49/275)	39.5 (98/248)
2010–2011	23.1 (62/268)	31.7 (103/325)

Competing interests None declared.

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PTU-262 ALCOHOL-MISUSE AND INPATIENT DETOXIFICATION: THE INCREASING WORKLOAD AND IMPACT OF AN ALCOHOL CARE TEAM AND ALCOHOL SPECIALIST NURSE (ASN) IN A DISTRICT GENERAL HOSPITAL

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Introduction The prevalence of alcohol misuse has risen dramatically over the past decade with younger individuals (aged 16–44 years) and women increasingly affected.[1] In 2007 24% adults were classified as hazardous drinkers (33% men, 16% women).[2] Over a 15-year period hospital admission rates for alcohol-related disorders have doubled,[3] with significant social and economic consequences. Recently, The British Society of Gastroenterology and NICE recommended an Alcohol Care Team including an ASN in every District General Hospitals to ensure early and effective inpatient treatment of patients with alcohol misuse; maximising compliance and reducing relapse. Studies indicate that an ASN generates 400 fewer admissions per year with shorter durations of stay and lower mortality rates.[4]

Methods We retrospectively audited the impact of the ASN on rates of inpatient referrals and medical detoxification regimes undertaken between 2004 and 2011 at Bassetlaw District General Hospital. Rates of commenced and completed detoxifications in addition to self-discharge data were obtained. Medical and surgical inpatients were included. Exclusion criteria: outpatient and A&E attendances, telephone referrals.

Results Between 2004 and 2011 the number of inpatient referrals for medical detoxification increased BY 657% (49–371 referrals per year). On average, the majority of inpatients were male (66%) and 48 years of age (range 17–90 years). Over a 7-year period the number of inpatient detoxifications commenced increased by 600% (24–168 detoxifications per year). Similarly, completed detoxifications increased by 517% (23 and 142 completed detoxifications in 2004 and 2011 respectively). On average 90.8% (714/786) detoxifications were completed prior to discharge. 9.2% (72/786) patients self-discharged prior to completing the detoxification regime.

Conclusion The workload of the Alcohol Care Team and ASN has increased substantially over a 7-year period, reflecting the rising prevalence of alcohol misuse and alcohol-related disease. The ASN provides early recognition and implementation of medical detoxification regimes for inpatients, offering support and continuity of care to maximise compliance and efficacy of treatment. Greater recognition and investment in alcohol services is essential within all UK District General Hospitals to minimise the growing burden of alcohol misuse.

Competing interests None declared.

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PTU-263 IS IT TIME FOR GASTROENTEROLOGY AND GENERAL MEDICINE TO GO THEIR SEPARATE WAYS?

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Introduction Currently most gastroenterologists within the UK are general physicians with a specialist interest in gastroenterology (85%) and most gastroenterology (GI) trainees train for dual accreditation in GI and general internal medicine (GIM). They therefore commit a major part of their time to the management of patients with GIM problems as part of their unselected acute medical take and ward work. With the development of "acute medicine" as a specialty in its own right and the formation of specialty-based wards to care for medical in-patients it has been questioned whether gastroenterologists should train to obtain dual accreditation in GI and GIM. The increasing demands for provision of GI services further support the conflict of whether training in GIM is required. With this in mind, we aimed to assess patients admitted with a primary GI complaint that should be triaged to a GI ward, the number of acute (active) non-GI diagnoses requiring acute treatment and whether these were managed by gastroenterology or whether referral to a specialist team was made.

Methods A single centre, prospective analysis of all patients admitted with a primary GI diagnosis during the unselected general medical take over a 6-week period (November 2011–January 2012)