data input and examination of the factors contributing to these data requires further investigation and analysis.

**Competing interests** None declared.

## PWE-073 COLONOSCOPY FOR A FAMILY HISTORY OF COLORECTAL CANCER: ARE WE SCREENING "THE WORRIED WELL"?

doi:10.1136/gutjnl-2012-302514d.73

A K Hunt,* S Qiu, Z Mohamed, I Beveridge, C E Collins, J Mawdsley, K Sundaram, K J Monahan. *Family History of Bowel Cancer Clinic, West Middlesex University Hospital, London, UK*

**Introduction** The British Society of Gastroenterology (BSG) updated guidelines for colonoscopic screening of people with family history (FH) of colorectal cancer (CRC) in 2010. In the UK, most patients anxious about their FH of CRC are referred by primary care doctors to non-specialist hospitals. Previous studies indicate guideline adherence is poor with significant clinical, medico-legal, and resource implications.

**Methods** Our study analysed adherence to the 2010 BSG guidelines in a district general hospital (catchment population of 300 000). Observational data were collected from all colonoscopies in which FH was the primary indication over a 16-month period from guideline publication up to April 2011 at our centre.

**Results** Of the 91 cases found (mean age 49.1 years, range 24.7–73.2), there were 11 high, 24 high moderate and 20 low moderate risk cases identified. 36 were low risk and did not fulfil criteria for initial colonoscopic screening. The 55 within guideline were screened on average 4.0 years early ($p<0.0002$; paired T test; 0–24.2 years early), with 18 cases screened early. 17 of the 91 cases were offered unnecessary follow-up colonoscopies. Yield for polyps and CRC was significantly lower in screened individuals (16/91 (18%)) compared to patients offered colonoscopies for other indications during the same period (246/838 (25%); $p=0.018$; $\chi^2$ test). Referrers recorded "reassurance" in 29 cases as a factor for screening.

**Conclusion** The BSG guidelines are based on robust evidence. Despite this, many patients (40%) undergoing screening in our centre do not meet guideline criteria. Some (33%) were screened too early, and others (19%) had unnecessary follow-up. Therefore, some patients are exposed to the risk of colonoscopy decades younger than recommended without justifiable benefits. This is reflected in similar data from other centres. Non-adherence to guideline occurs at multiple levels from referral and beyond. Clinicians often feel compelled to offer screening against guidelines for the reassurance of anxious patients. Our study identifies multiple opportunities where intervention could result in better adherence to guidelines; interventions such as the development of family cancer clinics outside clinical genetics centres to improve management of these patients.

Abstract PWE-073 Table 1

| Risk | Life time risk of CRC death | n (%) | Cases screened early | Inappropriate follow-up | Polyp/ CRC cases found |
|---|---|---|---|---|---|
| Appropriate for screening | | | | | |
| High (ie, known familial syndrome) | 1 in 2–5 | 11 (12%) | 0 | 0 | 2 |
| High moderate | ~1 in 6–10 | 24 (26%) | 6 | 8 | 5 |
| Low moderate | ~1 in 12 | 20 (22%) | 12 | 3 | 3 |
| Inappropriate for screening | | | | | |
| Low | >1:12 | 36 (40%) | NA | 6 | 6 |
| Total | | 91 | 18/55 (33%) | 17/91 (19%) | 16/91 (18%) |

**Competing interests** None declared.

## PWE-074 FACTORS THAT PREDICT SEVERE *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

doi:10.1136/gutjnl-2012-302514d.74

[1]A Sugumaran,* [1]M Eisa, [2]G Musiime, [2]F Mendes, [1]H Khan, [3]C Cefai. *[1]Department of Gastroenterology, Wrexham, UK; [2]Wrexham Maelor hospital, Wrexham, UK; [3]Department of Microbiology, Wrexham Maelor hospital, Wrexham, UK*

**Introduction** *Clostridium difficile* is a well-recognised infective cause for increased morbidity and mortality especially in hospitalised patients.[1] "Severe" CDI as defined by Health Protection Agency (HPA) is infection with stool positive for toxin, with white cell count $>15\times10^9$/l, or an acute rising serum creatinine (ie, >50% increase above baseline), or a temperature of >38.5°C, or evidence of severe colitis (abdominal or radiological signs). Increasing age, female sex, prolonged hospital stay, patient movement between wards, previous CDI, usage of proton pump inhibitors (PPI), histamine blockers (H2B) and antibiotics were reported to be associated with CD infection and colonisation,[2 3] but our aim was to check if the above factors predicted the severity of the infection.

**Methods** Data were collected from 392 patients who were diagnosed with CDI between January 2010 and December 2011. The CDI team (one Consultant, two nurse practitioners, one pharmacist) normally review patients twice weekly in our district general hospital. Details on the above risk factors were noted to study the correlation with severity of infection. Results were analysed with Pearson correlation test.

**Results** At the time of diagnosis, out of 392 patients, 206 were classified as "mild," 76 "moderate," 91 "severe" and 3 "life-threatening" infection (severity not documented in 16). Age distribution varied between 22 and 100 years, with 153 male and 239 female patients. 316 patients were on atleast one antibiotic when they developed CDI, chest infection being the commonest indication (36.8%). Amoxicillin was the most used antibiotic and the range of days on antibiotic varied between 1 day and long term usage (>3 years). 46% of patients were taking PPI while only 7.8% were on H2Bs. There were upto maximum four ward transfers and average of 17.62 inpatient days before CDI. Pearson correlation test showed there is no significant association between severity and any of the identified risk factors, closest being previous CD infection ($p=0.058$).

**Conclusion** Though there are definite risk factors associated with development of CDI, our study confirms that none correlate with the severity. More research is needed to clarify factors that will help identify hospitalised patients at risk of developing severe CDI.

**Competing interests** None declared.

### REFERENCES

1. **Leffler DA**, Lamont JT. Editorial: not so nosocomial anymore: the growing threat of community-acquired Clostridium difficile. *Am J Gastroenterol* 2012;**107**:96–8.
2. **Johnson S**. Recurrent Clostridium difficile infection: a review of risk factors, treatments and outcomes. *J Infect* 2009;**58**:403–10.
3. **Loo VG**, Bourgault A, Poirier L, *et al*. Host and Pathogen factors for CD infection and colonization. *N Engl J Med* 2011;**365**:1693–703.

## PWE-075 LACK OF ASSOCIATION BETWEEN THE PSCA RS2294008 POLYMORPHISM, OR PSCA EXPRESSION, AND COLORECTAL NEOPLASIA

doi:10.1136/gutjnl-2012-302514d.75

[1]C Smith,* [1]P Lochhead, [1]U Basavaraju, [1]G Hold, [2]N Fyfe, [2]G Murray, [1]E El-Omar. *[1]Gastrointestinal Research Group, University of Aberdeen, Aberdeen, UK; [2]Department of Pathology, University of Aberdeen, Aberdeen, UK*

**Introduction** Prostate stem cell antigen (PSCA) has been implicated in the pathogenesis of several solid tumours, either due to changes in