ketamine in group PK was 1.49 (0.61) mg/hg/h. There were no significant differences in patient tolerance, discomfort during insertion, patient and endoscopist satisfaction, haemodynamic responses, procedural pain, recovery time and recovery score. Overall, cardiovascular and respiratory adverse events were not significantly different between the two groups. These adverse events were transient and easily treated with no sequelae.

Conclusion IVS in both regimens provided effective and safe for colonoscopy. Adverse events were relatively high in both groups. However, these adverse events were mild and transient. No serious adverse events were observed.

Competing interests None declared.

PWE-106 IS IT NECESSARY FOR ALL COLORECTAL CANCER PATIENTS WITH LIVER METASTASIS TO BE DISCUSSED AT A HEPATOBILIARY MDT?

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Introduction Current guidelines suggest an opinion from a hepatobiliary MDT should be sought for all patients with colorectal cancer liver metastasis. This places a significant burden of work on the hepatobiliary MDT who are often the referral centre for many hospitals (Approximately 20 cases per month at our referral centre). This study was performed to see if our local colorectal MDT was able to make a correct decision regarding referral for consideration of liver resection by comparing its decision with the decision from two hepatobiliary surgeons from our referral network.

Methods CT scans from 38 patients found to have liver metastasis from colorectal cancer were anonymised and sent to two hepatobiliary surgeons in our cancer network (Pelican Centre, Basingstoke). They classified them into three categories; U—Unresectable, C—Chemo to downstage then consider resection and R—Resectable. The results were then compared with the opinion of our local colorectal MDT made prior to the referral to the hepatobiliary MDT.

Results The two independent hepatobiliary surgeons agreed with each other on 35/38 (92%) of the CT scans. Our CRC MDT agreed with the hepatobiliary surgeons in 36/38 (95%) of cases. Only 6/29 (21%) patients deemed suitable by review of the CT scan by the hepatobiliary surgeons went on to have a liver resection due to a variety of disease and patient factors.

Conclusion Our results show that our local colorectal MDT was able to make an accurate assessment of the need for referral for consideration of liver resection in this group of patients. We question the need for all similar cases to be "automatically" discussed with a hepatobiliary MDT such as those patients with wide spread liver disease. It is clear from the fact that only 21% of suitable patients for liver resection went on to have a resection that the colorectal MDT is making complex decisions based on many other patient factors.

Competing interests None declared.

PWE-107 POTENTIAL ROLE OF INTRAVENOUS IMMUNOGLOBULIN TREATMENT IN THE MANAGEMENT OF PATIENTS WITH SEVERE AND RECURRENT *CLOSTRIDIUM DIFFICILE* INFECTION

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Introduction Approximately 30% of patients with *Clostridium difficile* infection have recurrent disease, despite adequate treatment of the initial episode. Some patients with severe *C difficile*-associated disease (CDAD) fail to respond to standard treatment with oral vancomycin (125 mg three time a day). Intravenous immunoglobulin (IVIG) has been used in the management of these two groups of patients but no controlled trials have been reported and published clinical experience is mixed. We report our experience of the use of IVIG in these patients, including subsequent course of disease.

Methods Clinical information was collected prospectively and/or retrospectively (via review of case notes and hospital information system) in seven patients [median age 77 yrs (range 52—91 yrs), six female] with recurrent CDAD and five patients [62 (21—75) yrs, four female] with severe *C difficile*-associated colitis. IVIG was used at a dose of 400 mg/kg, rifaximin was given for 2 weeks (200 mg twice daily) and *Saccharomyces boulardii* for 4 weeks (125 mg four times a day).

Results Recurrent CDAD: median 5 (range 3—8) episodes of disease occurred over 9 (6—15) months. Two patients (4 and 7 episodes) were treated with courses of vancomycin and did not subsequently have a recurrence over the following 5 and 40 months (respectively). In addition to vancomycin courses, three patients received rifaximin (two also had *S boulardii*) and were free of recurrence over subsequent 15—27 months. One patient (8 episodes) failed to respond to the above treatment, but after IVIG, there has been no recurrence (20 months follow-up). By contrast, a patient with myeloma did not respond to three IVIG infusions. Severe CDAD: CT showed colitis in all, CRP—107 (58—366) mg/l, WBC—17.2 (4.8—39.7)$\times 10^9$/l. In addition to IVIG, all also had high dose oral vancomycin (500 mg four times a day) and intravenous metronidazole. Four (out of five) responded and were subsequently discharged and one had recurrence (responded to oral vancomycin). One patient, whose IVIG was delayed by 48 h after it was recommended, required a colectomy.

Conclusion (1) Some patients with multiple recurrences of CDAD may not require treatment in addition to courses of vancomycin but others may respond to IVIG. (2) There may be a role for IVIG in the management of patients with severe acute CDAD. (3) Our experience may facilitate identification of clinical characteristics to enable recruitment of suitable patients, with recurrent or severe CDAD, in multi-centre clinical trials of IVIG.

Competing interests None declared.

PWE-108 TOXIN A-SPECIFIC ANTIGEN-ACTIVATED AND MEMORY B CELLS IN THE CIRCULATION OF PATIENTS WITH *CLOSTRIDIUM DIFFICILE* INFECTION

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Introduction In *Clostridium difficile* infection, antibody-mediated immune response to secreted toxins A and B (which are also the main virulence factors) appears to be important in determining the nature of clinical disease. During a bacterial infection, activation of B cells leads to loss of immunoglobulin (Ig) D and expression of antigen-specific Ig on the cell surface. Following resolution of infection, antigen-specific memory B cells may be detectable in the circulation. Our aim was to identify circulating toxin A-activated B cells during clinical disease and toxin A-specific memory B cells following resolution of *C difficile* infection.