

**PMO-013 LACK OF AWARENESS OF NICE GUIDELINES ON ALCOHOL PRESENTATIONS AMONG PHYSICIANS INVOLVED IN THE MEDICAL TAKE AT A LARGE DISTRICT GENERAL HOSPITAL**

doi:10.1136/gutjnl-2012-302514b.13

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**Introduction** NICE have provided a framework to assess and manage alcohol related admissions and alcoholic hepatitis. The study aimed to assess the knowledge of, and compliance with these guidelines in a busy district general hospital.

**Methods** All physicians (f1 to consultant) involved in the medical take were sent an email survey via the website <http://www.surveymonkey.com> in January 2011. Six questions were posed to assess appreciation of the new guidelines with regards to the assessment of the alcohol withdrawal syndrome, correct prescription of parenteral thiamine and risk stratification, recognition and the specific management of alcoholic hepatitis. Free text and multiple choice questions were used. 39 doctors completed the survey; 15 were consultants and 24 junior doctors.

**Results** 100% of respondents correctly identified three symptoms or signs of the alcohol withdrawal syndrome. However only 13% recognised that the correct length of prescription of parenteral thiamine was at least 5 days in suspected Wernicke's encephalopathy. Only 40% identified the Maddrey score as a risk stratifier for alcoholic hepatitis and just 10% realised how high the mortality of the condition was during an acute admission. 49% appreciated that the specific medical management of alcoholic hepatitis was steroids or pentoxifylline. 21% of respondents would have discharged a patient with severe alcoholic hepatitis (Maddrey 32) from hospital. Results of responses from Consultants alone were broadly similar to the above pooled results.

**Conclusion** The burden of alcohol-related health problems on the NHS cannot be understated. National statistics report over a million acute admissions where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis, in 2009/2010—this is over double the number in 2002/2003. The results raise concern about the awareness of the management of alcohol related conditions among general physicians, especially the specific management of alcoholic hepatitis. Such patients thus suffer delays in diagnosis and management, possibly even increased morbidity; these delays lead to increased length of stay and repeated, expensive inpatient attendances. The role of the Gastroenterologist may be to be pro-active, rather than reactive in co-ordinating education, and service provision in this field. A guideline is in development locally that will be available to acute physicians via the intranet; it aims to simplify the management of alcohol-use disorder presentations. We aim to audit these presentations after introduction of the guideline and expect to show a significant improvement in standards.

**Competing interests** None declared.

## REFERENCE

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**PMO-014 AN INNOVATIVE MODEL FOR IMPROVING ACCESS TO AND UPTAKE OF TESTING AND TREATMENT FOR PATIENTS WITH CHRONIC HEPATITIS C IN THE SUBSTANCE MISUSE COMMUNITY**

doi:10.1136/gutjnl-2012-302514b.14

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**Introduction** There is a poor level of uptake of HCV/HIV testing in the UK particularly in the substance misuse community.<sup>1</sup> This

patient group employ a non-health centric paradigm with poor attendance to standard hospital outpatient appointments and engagement in health professional orientated screening programmes. Traditional testing requires venous access which can be difficult psychologically and practically in this group due to previous/ongoing IVDU. In addition the delay of up to 1 week for results has limited the success of improving access to services and subsequent follow-up for this patient group.

**Methods** New testing technology employing mouth swab testing with results available within 30 min were developed (OraQuick HIV/HCV testing kits, OraSure Technologies). Key workers from substance misuse agencies were selected and trained in blood-borne virus awareness, consent, harm minimisation and in the use of the point of care testing for HIV/HCV. These "Champions" who have daily contact with the substance misuse community offered screening for HCV/HIV. This model differed from previous attempts to engage this community in that it was not dependent on trained health care professionals for accessing and testing this community. Supervision of all "Champions" was shared between the DAAT manager, BBV nurse consultant and the relevant service managers.

**Results** In this pilot study 4 Champions tested 200 service users in comparison to 80 in the previous year using a non-Champion nurse based structure. Of the 200 patients screened, 32 were reactive for HCV infection. Of these 28 were HCV-PCR positive. 7/28 (25%) are currently undergoing a course of standard treatment. 19/28 (67.8%) are engaged in alcohol reduction or drug rehabilitation with a view to future treatment for HCV. 1/28 (3.6%) has moved out of area and only 1/28 (3.6%) was lost to follow-up.

**Conclusion** This innovative model has significantly improved access to testing and treatment for patients with HCV in the substance misuse community. Training selected key workers as champions allowed them to facilitate access to services for patients with substance misuse. Local Commissioners have further extended the scope of this project to allow training of six "champions" in the Asian community to improve access to testing and treatment for HCV in this community with a high prevalence of HCV.

**Competing interests** None declared.

## REFERENCE

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**PMO-015 WHAT IS THE CLINICAL RELEVANCE OF A MILDLY ELEVATED FAECAL CALPROTECTIN DETECTED IN NEW REFERRALS TO THE GASTROENTEROLOGY CLINIC?**

doi:10.1136/gutjnl-2012-302514b.15

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**Introduction** Analysis of faecal calprotectin (FC) is a non-invasive method for differentiating IBS from IBD. As a screening test, a normal FC has been employed to support a diagnosis of IBS, thereby avoiding invasive endoscopy in the patient cohort. We sought to investigate the diagnostic yield on subsequent colonoscopy in patients with mildly elevated FC and lower GI symptoms.

**Methods** Between November 2009 and November 2010, all patients with a FC value of 50–100 µg/g of stool (normal <50) were identified from our FC database. All of the stool samples were prepared and analysed according to the manufacturer's instructions (Bühlmann calprotectin ELISA kit). Patients were excluded from analysis if they were outwith the age range 16–50, had previous faecal calprotectin levels >100 µg/g stool, were known cases of IBD, had a history of NSAID intake, positive stool cultures, or any "alarm" GI