

Two HBeAg +ve patients attended booking too late to be eligible. Neonatal active and/or passive immunisation was recommended appropriately in all cases. Referral rates for eligible patients doubled following introduction of EPR. In the initial 6 months 32% of patients testing HBsAg positive at Maternity Services were referred to Hepatology (n=16) compared to 63% (n=33) following introduction of EPR. Mean gestation at referral improved from delivery date +2 weeks compared to 27 weeks gestation. Measurement of antenatal HBV DNA improved from 33% of patients referred to 81%. No HBeAg negative patient who had HBV DNA analysis had a viral load >10⁴ IU/ml. No patient had HBV DNA rechecked during pregnancy.

Conclusion Maternal seroprevalence in our population is high with most patients being new HBV diagnoses. An individualised liaison pathway for antenatal woman has improved service by:

Doubling referral rates to specialist services

Increasing potential access to third trimester Tenofovir if required

Increasing HBV DNA analysis rates without duplication of HBV DNA testing

To optimise preventative public health approaches to HBV wider use of this referral model should be considered in high prevalence settings. Education of the community and other health providers remains critical.

Competing interests None declared.

REFERENCES

1. **Stein HJ**, Sendler A, Fink U, *et al*. Multidisciplinary approach to esophageal and gastric cancer. *Surg Clin North Am* 2000;**80**:659–86.
2. **Weimann A**, Braga M, Harsanyi L, *et al*. European society of parenteral and enteral nutrition guidelines on enteral nutrition: Surgery including organ transplantation. *Clin Nutr* 2006;**25**:224–44.
3. **Scottish Intercollegiate Guidelines**. Sign 87 *Management of Oesophageal and Gastric Cancer: A National Clinical Guideline*. Quality Improvement Scotland, 1996.

PMO-018 DEDICATED SPECIALIST DIETETIC INPUT IMPROVES OUTCOMES FOR UGI SURGICAL CANCER PATIENTS

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Introduction Upper GI (UGI) cancer patients are at high risk of malnutrition increasing risk of complications post-operatively. Surgeons and Oncologists at Ninewells Hospital, Dundee funded an UGI Oncology Dietitian who oversaw nutritional care of patients through neoadjuvant chemotherapy, preparation for surgery and into follow-up. Previously at Ninewells, dietetic care of patients was ad-hoc resulting in reduced nutritional status during chemotherapy, admissions for feeding and delays to surgery. Once the post-holder joined the MDT it was important to show value for money and clinical effectiveness so data were gathered on outcomes for patients who had undergone UGI cancer surgery in the year before the post-holder started (n=49) and for 1 year afterwards (n=22).

Methods A literature search was performed using MEDLINE in order to compare results against other centres but no similar studies were found. Subsequently the MDT decided on clinical standards based on current evidence and acceptable limits including:

Patients will be referred to the Upper GI Oncology Dietitian prior to surgery.

Patients will maintain their weight during chemotherapy and surgical admissions within 5%.

All patients will have a jejunostomy tube placed at the time of surgery.

Data were gathered from medical and dietetic notes for each group on; whether patient was referred before surgery, weight (kg) at start and end of chemotherapy and on admission and discharge

from surgery, whether jejunostomy placed at time of surgery, length of stay (LOS).

Results

Standard	Pre postholder	With postholder
% Of pts maintaining weight within 5% during chemotherapy	50%	93%
% Of pts maintaining weight within 5% during surgical stay	20%	59%
% Of pts referred to dietitian pre-op	72%	100%
% Of pts with jejunostomy inserted at surgery	95%	77%
LOS	27 days	22 days

Conclusion Results showed the positive and cost saving impact of a dedicated dietitian on standards measured especially during chemotherapy and on LOS. The number of feeding tubes inserted fell in the group with dietetic input reflecting the types of surgery performed. Improved communication and leadership between the dietitian and the MDT helped to prevent admissions for pre-operative feeding and reduce delays. Further large studies are required, particularly in the peri-operative period, to further promote dedicated dietetic input.

Competing interests None declared.

PMO-019 EVALUATION OF EVIDENCE-BASED RECOMMENDATIONS IN CURRENT BRITISH SOCIETY OF GASTROENTEROLOGY GUIDELINES

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Introduction Clinical practice guidelines aim to improve patient care. They are based on best available evidence and are frequently viewed as “gold-standard” care for the disease or intervention that they address. The aim of this study was to determine the overall quality of the evidence supporting current British Society of Gastroenterology (BSG) guidelines.

Methods Guidelines were retrieved from the BSG website on 6th January 2012. Those posted after 2006 were considered current. The quality of supporting evidence was graded in accordance with the systems initially used to assess the primary literature. Adherence to the BSG’s advice on guideline writing issued in 2010 was assessed in guidelines published thereafter.

Results 18 BSG guidelines currently exist addressing topics in endoscopy (n=7), luminal gastroenterology (n=8), and hepatology (n=3). Four guidelines published in the study period were updates of previous guidance. These were published a median of 7.5 years after the initial guidance. Of a total of 434 evidence-based recommendations the quality of evidence was low in 42.8% (range 7.1%–85.7%), that is, from case studies or consensus opinions. High quality evidence-based recommendations (consistent data from randomised controlled trials) accounted for only 14.3% of all recommendations (range 0–45.5%). Overall, there was significant heterogeneity between guidelines. These were developed using four different evidence-grading systems. In those published since 2010 only one out of eight guidelines adhered to the evidence grading system advised by the BSG Clinical Services and Standards Committee.

Conclusion

1. Evidence-based recommendations in current guidelines are most frequently based on low quality evidence, reflecting a lack of available high quality evidence.