

**PMO-022 ARE RECOMMENDED GUIDELINES FOR IV PARACETAMOL PRESCRIPTION FOLLOWED IN SUSCEPTIBLE GASTROENTEROLOGY PATIENTS?**

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**Introduction** IV Paracetamol use has increased since gaining EU drug approval in 2002, possibly due to its rapid onset and favourable side-effect profile.<sup>1</sup> The recommended adult daily dose is 4 g/day. The standard daily dose may be high enough to cause acute liver failure in patients with certain Gastroenterological problems [hepatocellular insufficiency, chronic malnutrition<sup>2</sup> (The British National Formulary (BNF) version 60 advises that IV Paracetamol should be reduced to 3 g/day in these susceptible patients.<sup>3</sup> We aimed to assess if IV paracetamol prescriptions are in line with BNF guidance.

**Methods** A prospective, point prevalence audit of all patients receiving IV paracetamol was undertaken on 2 days, 2 weeks apart. All adult inpatients (excluding the Women's Department) at Arrowe Park Hospital were assessed. A list of all patients receiving IV paracetamol was identified through the electronic prescribing system. The case-notes of all these patients were reviewed for evidence of high-risk characteristics including; weight.

**Results** Over two audit days a total of 104 out of 1158 (9%) hospital inpatients were prescribed IV Paracetamol. Three patients were present on both days, therefore 101 sets of data were collected. 16 patients (16%) prescribed IV Paracetamol were identified as high risk (hepatocellular insufficiency, chronic malnutrition or chronic alcoholism), and 15 (94%) of these patients were not prescribed a reduced dose. This equates to a drug error in 1.3% of all inpatients.

**Conclusion** IV Paracetamol is prescribed very frequently. Prescription is common in susceptible Gastroenterology patients with malnutrition, liver disease and alcoholism. Almost all susceptible patients in this audit were prescribed an inappropriately high dosage of paracetamol. This may lead to significant adverse side effects in an already vulnerable group of patients. It is important to increase awareness of reduced dosages in susceptible patients. Locally an alert has been placed on the electronic prescribing system and we have increased Pharmacist and medical staff awareness of appropriate paracetamol doses. We suspect our audit findings may be similar in other hospitals.

**Competing interests** None declared.

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**PMO-023 ASSESSMENT OF QUALITY OF LIFE, COPING STRATEGIES AND PERSONAL BELIEFS IN ENDOCRINE TUMOUR PATIENTS**

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**Introduction** Medical research is focused on the developing of treatments and improving survival outcomes. In recent years, quality of life (QoL) measurements have been included in clinical trials as a relevant outcome variable; however, other psychological variables might have an impact on QoL. This study aims to determine: H1. Whether NET symptoms have a greater impact on QoL than disease

severity. H2. Whether coping strategies influence QoL. H3 Whether internal control beliefs in the potential of control cancer growth are associated with QoL.

**Methods** 74 patients completed a web survey involving: QoL (EORTC C.30 and GI.NET21), a coping styles (Brief cope) and an illness perception measurements. All questionnaires were counter-balanced.

**Results** Endocrine and gastrointestinal symptoms, were negatively associated with self-reported measures of QoL,  $r=-.46$ ,  $N=73$ ,  $p.05$ . Problem focus strategies such as acceptance, active coping and planning were not associated with QoL. Interestingly, emotion focus strategies such as behavioural disengagement, venting and self-blame were negatively associated with QoL,  $r=-.48$ ,  $N=73$ . Neuroendocrine patients considered that, keeping a positive attitude, not smoking and limiting alcohol intake would prevent cancer from spreading and progressing; however none of them were correlated with QoL.

**Conclusion** Disease severity is not associated with to QoL, whereas specific neuroendocrine symptoms, flushing and diarrhoea are. Active coping, acceptance, seeking emotional or instrumental support, were not correlated to QoL. In contrast, behavioural disengagement, denial and self-blame were negatively associated to self reported measures of QoL. Most of our patients endeavour on active or problem focus strategies where there is agreement of being more adaptive long term than avoidant or emotional strategies. This study has shown the relationship between neuroendocrine symptoms and coping strategies with QoL. Prospective and randomised trials will clarify the causal relationship among these constructs. Future research should include the relationship of psychosocial variables and neuroendocrine biomarkers.

**Competing interests** None declared.

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**PMO-024 A QUALITATIVE EXPLORATION OF INFLAMMATORY BOWEL DISEASE PATIENT ATTITUDES TOWARDS SELF MANAGEMENT AND NEW MODES OF CARE DELIVERY**

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**Introduction** Equity and excellence: Liberating the NHS (2010) states that new modes of care delivery must be explored for patients with long term conditions (LTCs). Increasing the proportion of people with a LTC to self care is a Quality Indicator and High Level Outcome in the Health and Well Being Strategy. The increasing focus on self care and reduction in inappropriate outpatient appointments are key priorities in commissioning services. The role of self management in IBD has been established but patient perceptions of self management programmes need to be addressed when implementing new modes of care delivery.

**Methods** The aim of this study was explore patient perceptions of self management as part of a follow-up care model. 24 in depth qualitative interviews were conducted, 18 patients had Crohn's Disease, six ulcerative colitis, age range 27–72 yrs. Disease duration range was 2–40 years. Patients were asked about self management,

participation in self management programmes, open access appointments and the value of their hospital appointments when well. Thematic analysis of interviews was undertaken using NVivo 9.0.

**Results** No patients were enrolled into a self management programme. Only two had heard of self management. Four clear groups of patients perspectives of self management emerged: (1) patients who embraced the concept of self management and questioned why they had not heard of it prior to the interview; (2) patients who dismissed self management and could perceive no advantages to it, would not take “responsibility for their body”; (3) patients who were willing to embark on a programme with the caveat that if they could not manage, they could revert back to the traditional care system; and (4) patients who required more knowledge about their illness and body response before considering self management. All patients were concerned about open—access and a fear of not “getting in” when needed. This led to an unwillingness to accept this yet all but one of the 24 patients stated that, when well, their hospital appointment was often a waste of their time and the healthcare professionals’ time.

**Conclusion** Integrated care pathways for patients with inflammatory bowel disease should be responsive to their clinical needs, be feasible and acceptable to those delivering and receiving care. When designing new modes of care delivery, consideration must be given to the group of patients that will not, or cannot self manage. Patients also appear to lack confidence in new modes of care delivery. Re-building this confidence is vital to the successful implementation of integrated care pathways where there is an element of self management.

**PMO-025** **THREE-YEAR REVIEW OF LOCAL HEPATO-PANCREATOBILIARY (HPB) CANCER SERVICE & ITS IMPACT ON CANCER DETECTION IN A NON-TERTIARY CENTRE IN MERSEY REGION**

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**Introduction** Patients with HPB cancer pose complex clinical problems requiring close liaison between primary, secondary & tertiary care. Reconfiguration of cancer services in the Mersey region has led to standardisation of care for HPB cancer patients via referral to Regional Specialist Centres (RSC). However local cancer care remained fragmented and limited by the variable expertise of the respective clinical teams involved. Therefore we developed a local HPB Cancer Service (HPBCS) and hereby report 3-year impact of this service on overall patient care and cancer detection rates outside tertiary referral centres.

**Methods** The HPBCS was launched on the Wirral in June 2008, the first such service in a large district general hospital (catchment population of 360 000) in the Mersey region. All patients with suspected HPB cancer were referred to the local HPB Team comprising of two HPB consultants and a specialist nurse. Patients are identified via 2-week referrals from primary care, acute admissions, ward referrals and radiology flags—a new concept that year upon year provides a valuable resource to the service. All patients are managed as per the Mersey & Cheshire Cancer Network protocol with discussion at the appropriate RSC MDT meetings. The team meets weekly to discuss all new referrals, MDT outcomes and any sick patients. In addition to the consultant clinics, there is weekly HPB nurse-led outpatient & telephone clinics that provides urgent feedback of tertiary MDT decisions, rapid access for symptom control and ensures continuity of care.

**Results** There is a sharp increase in the HPB cancer detection and referral rates since establishing the local HPBCS which has sustained over 3-year period as summarised in Abstract PMO-025 table 1.

Abstract PMO-025 Table 1

Pancreatic lesions	Pre HPBCS 2007		Post HPBCS 2009/2010/2011	
	Pancreatic cancer resectable/non-resectable	NA	59/24	72/40
IPMN	NA	45	83	48
Benign pancreatic lesions	NA	47	33	40
Total	51	175	252	178

  

Hepato-biliary lesions	Pre HPBCS 2007		Post HPBCS 2009/2010/2011	
	Cancers (HCC/gallbladder/cholangio)	NA	34/13/9	42/2/8
Benign liver lesions	NA	25	65	51
Indeterminate liver lesions	NA	21	4	18
Total	26	102	121	139

**Conclusion** Since commencement of local HPBCS, there is sustained increase in number of suspected HPB cancers identified within the trust. These are referred on to the regional MDTs within 2 weeks, leading to timely and uniform care as per regional network guidelines with local ownership of care. Service was formally praised in MCCN peer review in 2010 and awarded Wirral Trust Foundation Award in 2011. There is small but consistent rise in detection of liver lesions which may reflect increasing incidence of chronic liver diseases nationally. Ever increasing pool of surveillance patients & radiology alerts contribute to significant ongoing work load.

**Competing interests** None declared.

**PMO-026** **RE-AUDIT OF ACTION ON POSITIVE *H PYLORI* (HP) SEROLOGY: SIGNIFICANTLY BETTER ... NOT YET PERFECT**

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**Introduction** We identified a patient with duodenal ulcer re-bleed whose earlier *Hp* seropositive result was overlooked, hence not acted on. This triggered an audit<sup>1</sup> of action taken on hospital-initiated *Hp* seropositive results. It showed inadequate action in 17% due to multiple serology request sources, unclear advice from endoscopists & varied involvement of endoscopy specialist nurses (SpN). As most *Hp* serology tests were initiated at endoscopy, SpN were made the single point of contact to test, review/action results & confirm eradication by Urea Breath Test (UBT) in seropositives. Two actions were taken in November 2010: a copy of all hospital clinician initiated seropositive results to be sent by Microbiology lab to SpN & a code “ESN” created in the lab system for SpN to request & receive serology results directly.

**Aim** To re-audit management of *Hp* seropositive patients since introducing the above measures.

**Methods** Retrospective study of all hospital clinician initiated *Hp* seropositive results between January and June 2011 (list from microbiology lab database). Proof of action was got from our Medical Physics UBT database, SpN contact log, Endoscopy reporting software (endoscopist advice on testing & action if positive) and notes review when data not obtainable from these sources.

**Results** 90 seropositive patients identified; seven excluded from analysis as they died soon after test (cancer in most). *Action on Hp positive results*: 82/83(99%) results acted upon. One with metastatic cancer was tested (contrary to endoscopist advise) & result overlooked by ward team. SpN reviewed 75/82 (92%) patients and