patients died within 365 days (44.4% 1 year mortality) with an average age at insertion of 81.8 years.

Conclusion The 30-day mortality rate in this study mirrors that found in previous published data, with all known deaths due to respiratory disease; none were found to be procedure related deaths. This is despite careful patient selection, assessment by a multi-disciplinary team and the application of other recommendations of the NCEPOD report. It would be prudent for further review and audit of careful selection of appropriateness for PEG particularly in cases with multiple comorbidities with consideration into the futility of the procedure. Thus patient selection for PEG insertion remains a difficult problem.

Abstract PMO-044 Table 1

ASA grade	Overall patients	30-Day mortality	1 Year mortality
I (normal healthy patient)	3 (6%)	1 (11%)	1 (5%)
II (mild systemic disease)	25 (56%)	5 (56%)	8 (40%)
III (severe systemic disease)	16 (36%)	3 (33%)	10 (50%)
IV (life threatening systemic disease)	1 (2%)	0 (0%)	1 (5%)
Total	**45**	**9**	**20**

Competing interests None declared.

REFERENCES

1. **Mitchell SL,** Tetroe JM. Survival after percutaneous endoscopic gastrostomy placement in older persons. *J Gerontol A Biol Sci Med Sci* 2000;**55**:M735—9.
2. **Johnston S,** Tham T, Mason M. Death after PEG: results of the national confidential enquiry into patient outcome and death. *Gastrointestinal Endoscopy* 2008;**68**:223—7.

PMO-045 PERIOPERATIVE DIETETIC CONSULTATION LEADS TO IMPROVED NUTRITIONAL STATUS AT 2 WEEK FOLLOW-UP IN PATIENTS WITH OESPHAGOGASTRIC CANCER

doi:10.1136/gutjnl-2012-302514b.45

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Introduction Patients with oesophagogastric cancer are at high risk of malnutrition.[1] The aim of this study was to assess the effect of advice provided by a dietitian peri-operatively on nutritional status at first surgical follow-up. The period studied was prior to specialist dietetic services being funded, resulting in lack of capacity to see all patients referred.

Methods Consecutive records (n=60) of patients who underwent oesophagogastric resection between August 2010 and November 2011 and referred to the dietetic service were reviewed. Jejunally (n=19) and parenterally fed (n=4), palliative (n=3), stromal tumour resection (n=1), peri-operative deaths (n=1) and incomplete records (n=1) were excluded. Anthropometrics were collected on admission and at first surgical outpatient follow-up. Number of consultations and time spent with a dietitian was recorded. Data for patients referred but not seen was compared to those who received dietetic input. Effect was measured as percentage weight loss. Tests for normality were performed. T-test was used to determine significance.

Results 31 patients were included in the study. All were initiated on oral nutrition post-operatively. n=21 received dietetic input and n=10 did not. Patient characteristics were similar between both groups apart from tumour differentiation (p=0.046), sex (p=0.023) and weight loss on admission (p=0.148). Mean length of stay=12.8 days (SE 1.1) and time to follow-up= 22.8 days (SE 2.2) (p=ns). Weight loss percentage at follow-up between patients seen and not seen by a dietitian was 7.87 (SE 0.70) and 11.66 (SE 1.24) respectively (p=0.008). Adjusting for sex, tumour differentiation and weight loss on admission did not effect the result (6.88 (SE 0.93), 11.49 (SE 1.07) p=0.005). In the intervention group mean reviews by a dietitian=2.4 (SE 0.3) and time spent=138 min (SE 14). Regression analysis showed a tendency for attenuation of percentage weight loss on increasing time with a dietitian (r=0.33; p=0.142).

Conclusion Dietetic advice peri-operatively significantly attenuates weight loss at first outpatient follow-up. This effect may improve with increasing time spent with a dietitian. The data supports the Improving Outcomes Guidance on access to dietetic expertise. Although not found in this study, malnutrition is known to increase readmission and hospital stay.[2]

Competing interests None declared.

REFERENCES

1. **Bozzetti F.** Screening the nutritional status in oncology: a preliminary report on 1000 outpatients. *Support Care Cancer* 2009;**17**:279—84.
2. **Correia MI,** Waitberg DL. The impact of malnutruition on morbidity, mortality, length of stay and costs evaluated through a multivariate model analysis. *Clin Nutr* 2003;**22**:235—9.

PMO-046 AUDIT OF A NEW PATHWAY FOR ENTERAL FEEDING HEAD AND NECK RADIOTHERAPY PATIENTS

doi:10.1136/gutjnl-2012-302514b.46

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Introduction It is well recognised that Head and Neck Cancer (HNC) patients often "have problems with eating and drinking and a substantial proportion have to cope with tube feeding".[1] With no national pathway, many units use gastrostomy tubes however, clinical indication and timing of placement are debated.[2] Due to gastrostomy tube complications, our unit routinely uses nasogastric tubes (NGT). Using data from a previous audit our centre developed a pathway for enteral feeding (EF) HNC radiotherapy (RT) patients[3]. This pathway includes advice on enteral feeding in this patient group, specifically when and who to electively NG feed and guidance on selecting suitable patients for elective day-case NG placement. The pathway was launched in May 2011 and impact on length of stay (LOS) assessed.

Methods All patients with primary HNC treated with RT from 1st June to 30th September 2011 requiring EF were included in the audit. Details of anthropometry, day of RT NGT passed, LOS, number of NGT's required and nutrition related readmissions were collected.

Results 12 patients met the inclusion criteria; one was excluded from analysis as they were receiving long term gastrostomy feeding prior to RT. Details of the remaining 11 patients are detailed in Abstract PMO-046 table 1. Admissions >24 h occurred in two patients. One patient initially refused an NGT, subsequently needing admission for nutritional complications and an NGT. The second patient had laryngeal cancer, a diagnosis that doesn't normally require EF; therefore NG feeding was commenced due to unexpected late onset nutritional problems. Despite this using the pathway reduced the average LOS further to only 3 days.[3]

Abstract PMO-046 Table 1 (n=11)

Day-case	Overnight admission	>24 h admission	Refused NGT	Elective gastrostomy (pre-existing malnutrition)
3 (27%)	3 (27%)	2 (18%)	2 (18%)	1 (9%)