Abstract PWE- 182 Table 1

Year	30 Day Mortality		1 Year Mortality	
2005	11	21.6%	31	60.8%
2006	4	13.3%	12	40.0%
2007	4	13.3%	13	43.3%
2008	0	0.0%	7	36.8%
2009	4	11.8%	14	41.2%
2010	6	15.4%	18	46.2%
2011	1	3.8%	5	19.2%
2012	2	6.7%	6	20.0%
Mean	4	10.7%	13.25	38.4%

effective. 1 year mortality in MND patients is high and emphasises the importance of careful patient selection.

We recommend that other institutions with a high 30 day mortality following PEG adopt the changes in practise outlined above. Ongoing audit of our practise is required.

Disclosure of Interest None Declared.

PWE-183 DOES INSERTION OF A GASTROSTOMY CONFER ANY QUALITY OF LIFE BENEFIT TO EITHER PATIENTS OR THEIR CARERS?

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Introduction Gastrostomy feeding is an effective means of providing enteral nutrition to patients who have functionally normal gastrointestinal tracts but who cannot meet their nutritional requirements because of an inadequate oral intake. Whilst improvements in outcome measures such as nutritional status and mortality have been demonstrated in certain patients undergoing gastrostomy insertion, there remains a paucity of work evaluating another important health outcome measure, which is health related quality of life (HRQoL). Furthermore no previous study has looked at the impact on carers' HRQoL when considering all referral indications for gastrostomy. This prospective, multicenter study evaluates HRQoL in both gastrostomy patients and their carers, with comparisons made with a population control group.

Methods 61 patients (mean age 68 years) and 58 carers (mean age 65 years) were prospectively recruited from 4 hospitals in South Yorkshire between Feb-Dec 2012. All individuals had HRQoL evaluated prior to gastrostomy insertion, with repeated measurements undertaken at 3 months. Assessment was undertaken using EQ-5D, a validated assessment tool and preferential measure used by NICE, producing scores between 0 for dead and 1 for perfect health. Findings were then compared with a separate cohort of population controls (n = 419), to determine if differences existed in HRQoL. Non-parametric statistical analysis was undertaken using a Wilcoxon Rank test to compare longitudinal paired EQ-5D scores, and a Mann-Whitney test to compare EQ-5D scores between groups, with p values < 0.05 considered significant.

Results 61 gastrostomy patients have been assessed to date. Of these, 3 died prior the 3 month reassessment post insertion. No significant change was shown in mean EQ-5D scores in either the gastrostomy patients (0.74 versus 0.73, p = 0.11) or their carers (0.96 versus 0.97, p = 0.30) at 3 months following gastrostomy insertion. When compared to population controls, carers had comparable scores to the population controls unlike the gastrostomy patients who had significantly lower mean EQ-5D scores (0.73 versus 0.94, p < 0.0001).

Conclusion This study demonstrates that HRQoL does not significantly improve for patients or their carers following gastrostomy insertion. Given that gastrostomy feeding has no positive effect on HRQoL, questions must be raised as to the merits of this intervention if it only serves to improve physiological outcomes.

Disclosure of Interest None Declared.

PWE-184 THE ASSOCIATION OF DIETICIAN FOLLOW UP WITH THE QUALITY OF LIFE IN COELIAC DISEASE

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Introduction Coeliac disease (CD) is present in 1% of the UK population however there are still many undiagnosed cases in the community. The main treatment for this condition is gluten free diet. The role of dieticians in the follow up care of CD patients is crucial especially with regards to educating CD patients about their dietary requirement as well as their role in disease monitoring. The aim of the study is to assess the association of dieticians follow up on the quality of life in CD patients.

Methods CD patients who were identified on histology over a 10 years period in East Sussex were sent a socio-demographic questionnaire and the Coeliac Disease Quality of Life (CD-QOL) survey by post. The participants of the study who attend dietician follow up were then compared with those who did not. Multiple linear and logistic regression analyses were used to identify any significant relationships

Results Overall, 58 participants (34%) completed and returned the questionnaires. Dietician involvement appeared to be the most important predictor (beta = –0.424, p = 0.001) for overall CDQOL score but surprisingly, the negative value indicates that dietician involvement was associated with a lower quality of life score. Increasing age seemed to have a positive impact (beta = 0.312, p = 0.011) on overall quality of life. However, a change of the recent gluten free prescription (beta = –0.246, p = 0.037) which limits the products available and having initially presented with gastrointestinal symptoms (beta = –0.24, p = 0.044) were found to have negative contributions to the overall CDQOL score. The overall model fit was moderate ($R^2 = 0.336$). Logistic regression was used to identify the likelihood of dietician follow up and the only significant predictor identified was the overall CDQOL score (OR 0.95, p = 0.019) which indicates that those with higher quality of life score were less likely to have dietician follow up.

Conclusion Dietician follow up is associated with poorer quality of life but due to the nature of this study, cause and effect cannot be established. It may be that patients who have poorer quality of life chose to see a dietician and longitudinal study is required to further assess this association. This study also suggests that the recent change to the gluten free prescription has negatively impacted the quality of life of those with CD. This fact should be taken into consideration for any future health providers dealing with local CD service provisions.

Disclosure of Interest None Declared.

PWE-185 USE OF DEEP SEDATION FOR A PERCUTANEOUS GASTROPEXY SERVICE IN A DISTRICT GENERAL HOSPITAL

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Introduction All patients with head and neck cancer referred for nutritional support with enteral feeding to our unit undergo direct

puncture gastropexy placement as per the British Society of Gastroenterology guidelines published in 2010[1]. On introduction of the new technique we observed that standard sedation with intravenous pethidine and midazolam often led to patients tolerating the procedures poorly and occasionally to the procedures being abandoned. Therefore a decision was made to continue these procedures with 'deep' sedation supervised with a consultant anaesthetist using remifentanil, midazolam and diamorphine. We present our data for the 18months until January 2013 using deep sedation.

Methods The details of all patients attending for gastropexy procedures in East Kent between June 2011 and 11th January 2013 were reviewed to assess the type of sedation used, patient comfort (measured using the modified Gloucester score and assessed by the endoscopy nursing staff post-procedure) and complications.

Results 35 patients (M: 31, F: 10, mean age 61, range 43yrs- 72yrs) underwent gastropexy procedures under deep sedation.

The mean time taken to perform the procedure under deep sedation was 23.3 minutes +/- standard deviation of 4.6minutes. Range from 14–29 minutes.

A total of 27 patients reported no discomfort and were resting comfortably throughout the procedure. 4 cases recorded to have experienced one or two episodes of mild discomfort but had tolerated the procedure well and 4 cases of minimal discomfort were reported, again the procedure was well tolerated. There were no reported complications (immediate or late).

Conclusion Patients with head and neck cancers undergoing gastropexy procedures tolerate these procedures far better under deep sedation. We would recommend that such an approach improves the welfare of our patients and recommend its use to colleagues.

Disclosure of Interest None Declared.

REFERENCE

1. Westaby *et al.* The Provision of a Percutaneously Placed Enteral Feeding Tube Service. Gut 2010; 59: 1592- 1605

PWE-186 EFFECTIVE, SAFE MANAGEMENT OF STARVED PATIENTS WITH ANOREXIA NERVOSA THROUGH A COMBINED MEDICAL & PSYCHIATRIC APPROACH-MEETING THE MARSIPAN CHALLENGES

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Introduction Anorexia Nervosa (AN) has the highest mortality rate of any psychiatric condition. These patients are a challenge to manage because of severe physical and psychiatric morbidity. MARSIPAN reported that some patients with severe AN admitted to medical wards were deteriorating & occasionally dying because of delays in treating their medical conditions due to obstructive behaviours relating to their psychiatric morbidity[1]. It recognised a need for specialist teams including a psychiatrist and physician with an interest in eating disorders. There is a medical team providing in-patient medical management at University Hospital North Tees (UHNT) with support from the community eating disorders (ED) team.

Methods A retrospective audit of management of AN admissions due to starvation (BMI 13 or less) to UHNT June 2010-June 2012. Data collected from medical notes-audited against MARSIPAN standards.

Results 10 patients identified, all female. Age 18–43 (median 24.5). 9 known to ED service. Median admission BMI 12.8 (9.7–13). **Assessment:** All had recommended blood tests. 8 had an ECG; 2 abnormal (long QTc, heart block). **Monitoring**: 9 had appropriate electrolyte monitoring. All weighed twice weekly & had complete fluid balance charts. **Management:** 8 seen by ED physician within 48 hours (5 within 24 hrs), 6 seen by dietitian by 48 hours. All received pabrinex, 9 vitamin B & multivitamins. 4 did not receive DVT prophylaxis. All reviewed at least weekly by psychiatric ED team. 7 NG fed, 4 began NG feed within 24 hours, all established by 48 hours. 7 required electrolyte replacement. **Complications:** Re-feeding syndrome (7), pneumonia (2), ITU admissions (2; pneumonia, abnormal electrolytes). 3 exhibited problematic behaviour; 2 required 1 to 1 nursing. All complications recognised early. **Discharge:** All had discharge plans agreed by the ED team, 5 discharged to the ED unit.

Conclusion The ED team at UHNT provides a successful specialist service for the medical care of patients with severe AN. A median admission BMI of 12.8 indicated early identification & intervention of at risk community patients through this integrated approach. Patients are appropriately assessed & monitored & NG feeding is quickly established. Management of these patients by the multidisciplinary team enables the medical and behavioural challenges to be dealt with effectively and ensures timely discharge once medically stable. Through the development of trust guidelines we hope to further improve care of this vulnerable group.

Disclosure of Interest None Declared.

REFERENCE

1. MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa, College Report 162, Royal College of Psychiatrists and Royal College of Physicians London, October 2010

PWE-187 ETHANOL AND TAUROLIDINE LINE LOCKS FOR THE REDUCTION AND TREATMENT OF CATHETER RELATED BLOOD STREAM INFECTIONS IN PAEDIATRIC INTESTINAL FAILURE: A SYSTEMATIC REVIEW

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Introduction Paediatric intestinal failure (PIF) patients are often dependent on home parental nutrition (HPN) nd rely upon a central venous catheter (CVC) for its administration. There is a significant risk of catheter-related blood stream infections (CRBSI) with associated morbidity and mortality. Studies have suggested that the use of specialist line locks with ethanol or taurolidine may significantly reduce CRSBI for PIF. Our aim was systematically review the evidence for effectiveness of ethanol and taurolidine line locks in the prevention or treatment of CRBSI in PIF.

Methods Systematic retrieval of data from studies of PIF (PN > 28 days, age < 18yr). Outcome measures were the reduction in rates of CRBIS or eradication of CRBSI. Electronic searches of the Cochrane Library, MEDLINE (1946 –Jan 2013) and PUBMED (to Jan 2013) were made using keyword and MeSH terms 'Intestinal failure' 'child' 'ethanol locks' and 'taurolidine locks'. Hand searches of meetings of relevance and personal collections were also perfomed. Two authors

Abstract PWE-187 Table 1

Name	Intervention	EL	Patients	Reduction in CRBSI rate per 1000CVC days or treatment outcome
Jones	70% ethanol	2-	23	9.9 to 2.1
Wales	70% ethanol	2-	10	10.2 to 0.3
Pieroni	70% ethanol	3	6	Prevention of recurrence of fungal sepsis
Blackwood	70% ethanol	3	2	No recurrence of fungal sepsis
Cober	70% ethanol	2-	15	7.9 to 0.5
Onland	70% ethanol	3	9	Eradication of Rx resistant CRBSI
Mouw	70% ethanol	2-	5	11.5 to 2.3
McGrath	70% ethanol	3	7	Eradication of Rx resistant CRBSI
Chu	Taurolidine	2-	19	8.6 to 1.2