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