

## REFERENCE

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**PWE-193** CHANGES IN TASTE PREFERENCE AFTER COLORECTAL SURGERY

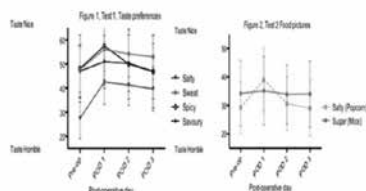
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**Introduction** Early postoperative nutrition is of clinical benefit. However, patients are often initially reluctant to eat after surgery. Dysgeusia and alterations in food preference are often reported. We conducted a study to describe perioperative changes in taste and food preference with a view to being able to optimise food choices and thus improve intake.

**Methods** Patients undergoing colorectal surgery were recruited. Three sets of tests were conducted, pre-operatively and on post-operative days (POD) 1, 2 & 3. In Test 1, patients were asked to rate the palatability (Horrible-Nice, using Likert scales (0–100%)) of a nutritional supplement flavoured with 'standard' concentrations of the 6 core tastes (sweet, sour, salt, bitter, spicy & savoury). In Test 2, patients were shown photos of foods representative of the core tastes and asked to rate them in terms of appeal. Test 3, snack box containing representative foods of the core tastes were rated by patients. Differences from baseline were assessed using t-tests.

**Results** 31 patients completed the study, M:F = 21:10, median age of 72 (33–82). Test 1, enhanced taste from baseline was seen on POD1 ( $p < 0.01$ ) for salty, sweat & spicy taste figure 1. Test 2, only salty food (popcorn) scored higher ( $p < 0.01$ ) than baseline (figure 2) all other foods scored lower. Foods representing bitter and sour exhibited the greatest decline (40.4% for gherkins, 38.7% for grapefruit). Test 3, patients rated sweat (fudge) 63%, salty (crackers) 50% best at POD 1 ( $p < 0.01$ ) and sour (gherkins) 22%, spicy (Bombay mix) 16% worst. With all 3 Tests, scores reverted to baseline by POD 3.



**Abstract PWE-193 Figure**

**Conclusion** After surgery patients rated sweat and salty snack foods greatest. This was confirmed by tests of palatability and appeal. Though while spicy and savoury palatability tests scored highly patients did not find the snakes particularly desirable. Further work is required to explore patients food preferences post surgery.

**Disclosure of Interest** None Declared.

**PWE-194** RANDOMISED STUDY OF RIGJ VS PEGJ IN PATIENTS AT RISK OF ASPIRATION PNEUMONIA

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**Introduction** In patients at risk of aspiration pneumonia due to gastro-oesophageal reflux who require gastrojejunostomy feeding tubes, the tubes are placed either radiologically (RIGJ) or endoscopically (PEGJ). There is little published evidence to inform which is superior.

**Methods** Consecutive patients referred for long-term jejunal feeding because of high risk of aspiration pneumonia (proven GORD or pneumonia whilst being NG fed) were randomly allocated to have a RIGJ or PEGJ inserted. A Tc<sup>99m</sup> colloid study was done to determine the presence of gastro-oesophageal reflux and jejunal gastric reflux after feeding tube placement. We recorded pneumonia, death, feeding tube displacement, blockage and replacement to 90 days post placement.

**Results** 65 patients were randomised, 31 RIGJ and 34 PEGJ. Baseline characteristics including Barthell index were similar between groups. GORD was demonstrated by Tc<sup>99m</sup> tracer injected intragastrically in 52% but in no patient when injected jejunally.

Jejunal feeding tube and clinical complications (number).

**Abstract PWE-194 Table 1**

	RIGJ n = 31		PEGJ n = 34			
	30days	30–90days	Total	30days	30–90days	Total
*p < 0.05						
Jejunal tube fallen out of position	0	0	0	7	2	9*
Jejunal tube irreversibly blocked	3	0	3	3	2	5
Jejunal tube replaced	2	0	2	5	3	8
Blockage cleared by patient/carer	8	4	12	22	12	34*
Blockage cleared by community H/C	2	2	4	8	3	11
Blockage cleared in hospital	3	0	3	10	5	15*
Further Pneumonia	2	1	3	2	3	5
Death	2	2	4	2	1	3

**Conclusion** There was little difference in clinical outcomes between RIGJ vs PEGJ tubes for feeding patients at high risk of pneumonia. However, RIGJ tubes were considerably less prone to blockage and displacement than PEGJ tubes. Tube blockage was a major cause of frustration for patients and resource use for health care services. Replacing enteral tubes in frail patients was distressing and a significant use of health care resource. Consideration should be given to placing RIGJ in preference to PEGJ tubes.

**Disclosure of Interest** None Declared.

**PWE-195** OUTCOMES OF NUTRITIONAL ASSESSMENT AND GASTROSTOMY IN PATIENTS WITH MOTOR NEURONE DISEASE (MND): A 4 YEAR EXPERIENCE

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**Introduction** Motor neurone disease (MND) is a fatal, progressive, neurodegenerative disease with a median survival from onset of symptoms of 4.32 years. No controlled trials indicate a benefit, although current guidelines recommend gastrostomy tube placement when dysphagia or weight loss occurs. Changes in our local practise occurred in 2011 in order to reduce time to referral, we assessed the outcome.

**Methods** We reviewed records of all patients referred with MND to the nutrition team and analysed their outcomes including nutritional assessment, decision for gastrostomy, type and survival.

**Results** Since 2009, 76 patients were referred for nutritional assessment in MND. Nine were excluded (5 not reviewed; 4 re-referred).

Baseline data: male 62.5%; mean age at diagnosis 63.9 years; mean body mass index (BMI) at referral 23.1kg/m<sup>2</sup>; 75% had lost weight at review with mean weight loss of 17%. Non invasive ventilation (NIV) was used in 54% of patients. Forty-four patients (66%) consented to gastrostomy tube insertion. Ten patients (15%) declined and 13% of patients were not appropriate as MND was too advanced. In four patients (6%) tube placement was not yet indicated.

Over 66% of patients had a radiologically inserted gastrostomy (RIG) tube and remainder a percutaneous endoscopic gastrostomy (PEG) tube. Patients had PEG placement if they had normal respiratory function (overnight oximetry, vital capacity and no NIV). Placement was unsuccessful in 3 patients (RIG 2; PEG 1); 2 had jejunostomy and one (RIG) declined further intervention. Five patients had complications; two (RIG) had pneumoperitoneum (managed conservatively); two had chest infections (RIG 1, PEG 1) and one had a site infection.

30-day (%) mortality as follows: no tube placed, 39; patient declined, 30; too unwell, 66; not yet indicated, 0. 1-year mortality (%) as follows: no tube placed, 74; patient declined, 70; too unwell, 78; not yet indicated, 25.

Overall mortality (%) in tube placement as follows: 30-day, 11; 1-year, 57 (RIG, 30-days, 10; 1-year, 68; PEG, 30-days, 13; 1-year, 43).\*

Abstract PWE-195 Table 1 showing mortality by year

	2009	2010	2011	2012	Overall
Total assessments	3	17	27	20	67
Mean time from MND diagnosis to referral (months)	43.3	22.8	21.2	13.7	19.5
Number of tubes placed (%)	2 (66)	12 (70)	16 (59)	14 (70)	44 (66)
30-day mortality (%)	0	8	18	7	11
1-year mortality (%)	0	58	62	**	57*
Overall mortality (%)	33	92	63	20	59

\*2009–11 \*\*cannot assess

**Conclusion** Our results show high short-term mortality in all patients referred for nutritional assessment with MND, demonstrating the advanced stage of disease as nutritional status deteriorates. Mortality is lower in the PEG group; a reflection of less respiratory comorbidity or disease stage?

Patients are being referred at earlier stages in their disease; appropriately identifying patients who benefit may provide better outcomes.

**Disclosure of Interest** None Declared.

## PWE-196 PREVALENCE OF OBESITY, BY SPECIALTY, AMONGST INPATIENTS IN THE SOUTH OF ENGLAND

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**Introduction** Rates of obesity, defined by Body Mass Index (BMI)  $\geq 30\text{kg/m}^2$ , are rising in the United Kingdom. The prevalence, by specialty, of obesity amongst inpatients has not been well studied.

**Methods** A multicentre, hospital-wide audit across three Trusts in the South of England was performed on a single day to ascertain the prevalence of obese inpatients by specialty. Patients were classified according to specialty (medical, surgical, orthopaedic, intensive care) and allocated a BMI category based on National Institute for Clinical Excellence guidelines (1).

**Results** 1163 patients were audited (575 male). 778 were medical patients, 222 surgical, 130 orthopaedic, and 33 intensive care.

Mean age was 69.3 years with a significant mean age difference between specialties (medical 71.4, surgical 67.7, orthopaedic 61.9, intensive care 60.4) and independent of the hospital studied.

260 patients (22%) had a BMI  $\geq 30\text{kg/m}^2$ , of which 103 (9%) had a BMI  $\geq 35\text{kg/m}^2$ . A significant difference in this latter group was observed between specialties (orthopaedic 18%, intensive care 9%, surgical 9%, medical 7% ( $p < 0.001$ )).

No effect of gender was observed but there was an independent effect of increasing age and higher BMI.

**Conclusion** Approximately one quarter of inpatients in our multi-centre audit were obese according to BMI criteria with 9% significantly obese (BMI  $\geq 35\text{kg/m}^2$ ). Rates of obesity are similar to rates of malnutrition in hospitals. Higher BMI were observed in orthopaedic and intensive care specialties than in medical and surgical. Doctors, nurses and managers should be aware of this variation for training and resource allocation purposes.

**Disclosure of Interest** None Declared.

## REFERENCE

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## Radiology

### PWE-197 IS MRCP A USEFUL INVESTIGATION WHERE THE BILIARY TREE IS NORMAL ON PREVIOUS IMAGING?

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**Introduction** Magnetic Resonance Cholangiopancreatography (MRCP) is increasingly used in the diagnosis of biliary disease, especially in stone disease. It has a high sensitivity and specificity [1] [2]; however its role in the absence of dilated biliary tree on previous imaging is not clear. The aim of this study was to determine the diagnostic yield of MRCP in patients with an undilated biliary tree.

**Methods** We performed a retrospective observational study of MRCP studies ( $n = 119$ ) performed between October 2011 and September 2012 at West Middlesex University Hospital using electronic medical records. All MRCPs were reported by a consultant radiologist. MRCP findings were correlated with the presence of dilated (but otherwise normal) or undilated biliary tree on initial imaging (USS/CT), jaundice (bilirubin  $> 21\ \mu\text{mol/L}$ ) and abdominal pain. Demographics including age and gender were noted. Fisher's exact test was used to analyse binary variables and student's T test for continuous variables using the STATA12 statistical software

**Results** In patients with a normal biliary tree on previous imaging the yield of MRCP was low with only 2/44 demonstrating stone or other pathology ( $p = 0.0002$ ). Patient referred for MRCP without biliary tree dilatation had a median age 12 years younger ( $p = 0.033$ ) and the indication was more likely to be pain ( $p = 0.017$ ) but not jaundice ( $p = 1$ ) and referrals were not gender related ( $p = 0.23$ ).

**Conclusion** Our study demonstrates a low diagnostic yield of MRCP in the absence of dilated biliary system on previous USS/CT. Furthermore, the presence of jaundice or abdominal pain does not help to select patients who may benefit from further biliary imaging with MRCP. Routine MRCP in patients with an undilated biliary tree on USS/CT does not appear to be indicated.

**Disclosure of Interest** None Declared.

## REFERENCE

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