improving individual SSP and team working. It aims to be of benefit to the organisation and the individual SSP.
Disclosure of Interest None Declared.

Service development

PTH-125 A NEW LOWER GASTROINTESTINAL 2-WEEK WAIT 'DIRECT TO TEST' PATHWAY RESULTS IN EARLIER DIAGNOSIS OF CANCER

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Introduction As part of the National Awareness and Early Diagnosis Initiative (NAEDI)[1], a symptom awareness campaign for bowel cancer was piloted in the UK in 2010 and 2011. The results suggested that referrals from primary care would increase by up to 30% when extended nationally from 30th January 2012. As a result, a new two-week wait (2WW) pathway for suspected colorectal cancer was developed at North West London Hospitals NHS Trust that aimed to decrease the projected burden on colonoscopy and triage the majority of patients direct to an appropriate diagnostic test - 'direct-to-test' (DTT), in order to reduce the time and number of appointments before cancer is diagnosed. Previously, patients were triaged to either an out-patient appointment or flexible sigmoidoscopy (FS); the new DTT pathway triaged patients to either FS, colonoscopy, CT colonography (CTC) or an out-patient appointment based on age and symptomatology.
Methods Outcome data for all patients referred via the old pathway for the months of May 2011 and January 2012, and those seen via the new DTT pathway for March 2012 and May 2012 were audited to assess clinical effectiveness.
Results There was a 33% increase in patients referred with suspected lower GI cancer following the NAEDI campaign, and this was sustained to May 2012. On the previous pathway the majority (60%) of patients were seen first in out-patients before a diagnostic test was requested, whereas over 85% of patients proceeded DTT with the new pathway. There was no significant difference in the proportion of colonic and extra-colonic cancers diagnosed between the two pathways, however more patients were diagnosed with colorectal polyps using the new pathway. Patients with cancer referred via the DTT pathway had a significantly reduced median time to diagnosis compared to those on the old pathway (10 days vs 15 days respectively, $p < 0.05$), and patients seen via the new DTT pathway had significantly fewer hospital appointments compared to those seen on the old pathway (1.9 vs 2.8 respectively, $p < 0.0001$).
Conclusion Symptom awareness campaigns increase demand for colorectal diagnostic services. We have demonstrated that a new DTT 2WW pathway for suspected colorectal cancer reduces the time to diagnosis of colonic neoplasia, whilst increasing outpatient capacity by involving fewer hospital attendances. Use of CT colonography for older patients decreases the burden on diagnostic colonoscopy, creating more targeted therapeutic endoscopy capacity.
Disclosure of Interest None Declared.

REFERENCE

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PTH-126 A FUNCTIONAL MODEL OF OF A 'SEVEN DAY ACUTE GASTROENTEROLOGY SERVICE': LOOKING BEYOND OUT-OF-HOURS ENDOSCOPY

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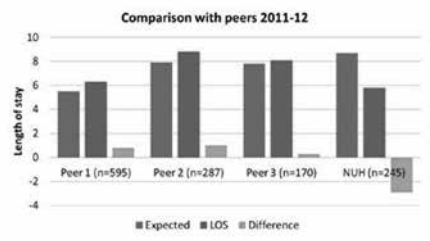
Introduction Early involvement and management by specialists has been shown to have a favourable impact on outcomes in a number of acute medical conditions. Increased patient mortality at weekends has also been attributed to limited access to specialist services. While an increasing number of hospitals provide an out-of-hours service for upper gastrointestinal bleeding, examples of a comprehensive acute Gastroenterology services are infrequent.
Methods In January 2007, we established an acute gastroenterology service to provide consultant-lead assessment and management for all patients identified through acute servieces with symptoms related to gastrointestinal and hepato-pancreatico-biliary conditions. The consultant of the week lead and delivered the service supported by a registrar and a dedicated inpatient endoscopy team, free from any commitment to elective services. Inpatient care was supported by daily consultant led ward rounds. We achieved the 'critical mass' to deliver this service by consolidating all inpatient work on on site.
Results Mean LOS of all patients discharged with a gastroenterology HRG, from the specialist gastroenterology ward was 7.6 days, and from non-specialist medical beds was 9.6 days. Overall the specialist gastroenterology ward provided care for 1.8 times more patients compared with other Medical wards of the same size at NUH. Actual mean LOS (for the period of 2011–2012) was significantly shorter than the 'expected' LOS, and than mean peer LOS for 4 main diagnostic categories (table) with no significant increase in readmission rates. Discharge rates were maintained at the same level during the weekend (mean 4 discharges per weekday and on Saturday, with a peak of 6 discharges on Fridays and a dip to a mean of 3 discharges on Sunday.

Abstract PTH-126 Table 1

Diagnosis	NUH actual LOS (days)	NUH expected LOS (days)	Peer mean LOS (days)	% difference
GI Bleed	4.2	5.8	5.8	-27%
Acute colitis	6.3	7.2	7.6	-15%
ALD	6.6	11.7	11.5	-43%
Other liver disease	5.8	8.7	6.9	-15%



Abstract PTH-126 Figure 1

Conclusion Specialist led care can be provided to all patients with acute gastrointestinal and hepato-pancreatico-biliary conditions. A functional 7-day 'acute gastroenterology' can be sustained to provide high quality and intensity of care with favourable outcomes.
Disclosure of Interest None Declared.

PTH-127 APPROPRIATENESS OF USE OF MRCP (MAGNETIC RESONANCE CHOLANGIO-PANCREATICGRAPHY) IN PATIENTS WITH SUSPECTED CBD STONES – A DISTRICT GENERAL HOSPITAL EXPERIENCE

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Introduction Patients with CBD (Common Bile Duct) stones require high risk interventions. Around 10–20% patients with symptomatic gallstones have CBD stones. Where the initial clinical, biochemical and ultrasound examinations failed to correctly predict CBD stones in a patient with gall stones, one should resort to either MRCP or EUS (Endoscopic Ultrasound) depending on the local expertise. Without the availability of either national or local proposed strategy for these investigations we feel either test may be inappropriately used. Our aim was to study the clinical details of patients undergoing MRCP for the suspected CBD stones and assess for their appropriateness.

Methods We randomly selected 45 patients who underwent MRCP for suspected CBD stones in the last one year. We assigned the risk of choledocholithiasis based on ASGE (American Society Gastrointestinal Endoscopy) guidelines and compared with their suggested management strategy. Finally we assessed their appropriateness based on the predictive factors and MRCP findings.

Results There were 28 females and 17 males. The age range was 21 to 91 years (mean 63.7 yrs). Based on the ASGE guidelines we assigned 24 (53.33%) patients to intermediate, 16 to low (35.55%) %) and 5(11.11%) to high likelihood of choledocholithiais based on clinical predictors. Only 6 patients (13.33%) had choledocholithiasis on MRCP three in high risk (3/5), 3(3/24) in intermediate risks and none (0/16) in low risk group

Conclusion Our audit suggests inappropriate use of MRCP in patients with low predictable group (35%). We feel those patients with high predictability should be carefully considered directly for ERCP. Currently we are extending this audit and also plan to re-audit after formulating local guidelines for the use of MRCP in suspected bile duct stones. We feel with careful clinical judgement, MRCP can be used selectively in those patients where it is going to be more useful and saving these radiological slots for more needy patients in a busy DGH.

Disclosure of Interest None Declared.

REFERENCES

1. Guidelines on the management of common bile duct stones (CBDS) - BSG Guidelines July 2008
2. The role of endoscopy in the evaluation of suspected choledocholithiasis- ASGE Guidelines GI Endoscopy Vol 71, No 1 2010

PTH-128 THE FRAX ALGORITHM IS OF LIMITED UTILITY IN PREDICTING OSTEOPOROSIS IN COELIAC DISEASE

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Introduction Osteoporosis is the commonest complication of coeliac disease yet no reliable scoring system exists to guide patient selection for bone density measurement. The FRAX tool has been developed by the World Health Organisation to estimate fracture risk based on clinical factors and incorporates causes of secondary osteoporosis such as coeliac disease (1). We have analysed the utility of FRAX in identifying osteoporosis in a cohort of patients with coeliac disease.

Methods 170 patients were recruited from coeliac clinics between October 2011 and 2012. 17 patients in whom bone mineral density results were not available were excluded, yielding a final study population of 153. Information on clinical risk factors for osteoporosis were collected by questionnaire. Two-tailed independent student t-tests, Mann Whitney U test or Chi-square tests were applied as appropriate. Statistical analysis was performed on SPSS.

Results

Abstract PTH-128 Table 1

Risk Factor	Controls (n = 130)	Osteoporotic Patients (n = 23)	p-value
Age at DEXA, mean (IQR)	52.4yrs (22.2)	69.6yrs (13.36)	< 0.001
Sex (Female)	91 (70%)	17 (73.9%)	0.895
Weight, mean (IQR)	67.9kg (16)	60.4kg (12.2)	0.001
Height, mean ±S.D.	166cm ± 8.36	162cm ± 7.78	0.023
History low trauma fracture	7 (5.5%)	4 (17.4%)	0.067
Family history of osteoporosis	27 (20.9%)	5 (21.7%)	1.000
Current smoker	14 (10.8%)	5 (21.7%)	0.168
History of glucocorticoid use	5 (3.9%)	4 (18.2%)	0.034
Alcohol, > 3units/week	10(7.8%)	1 (4.3%)	0.567

The prevalence of osteoporosis in our cohort was 15% (23/153). The distribution of risk factors used in the FRAX algorithm are shown in table 1. Factors significantly associated with osteoporosis in our cohort included increasing age, reduced height, weight and history of glucocorticoid use. The median 10 year risk of major osteoporotic fracture was 6.7% (interquartile range 8.5). A ROC analysis of FRAX as a predictor of osteoporosis yielded an area under the curve of just 0.614.

Conclusion The FRAX algorithm is not a reliable predictor of osteoporosis. A screening threshold of > 10% 10 year risk of major fracture gives a sensitivity of 43% and specificity of 73% for detection of osteoporosis. A lower threshold of 5% 10 year risk only increases sensitivity to 78% at a cost to specificity of 59%. Further work in constructing specific risk predictors for osteoporosis in coeliac disease is required.

Disclosure of Interest None Declared.

REFERENCE

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PTH-129 DEVELOPMENT AND ASSESSMENT OF A PATIENT INFORMATION LEAFLET RELATING TO THE HARMFUL EFFECTS OF EXCESSIVE ALCOHOL CONSUMPTION. A PROSPECTIVE SURVEY FROM A DISTRICT GENERAL HOSPITAL

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Introduction Alcohol abuse is a major cause of preventable liver disease world wide. Alcohol related liver disease and associated death is rising at an alarming rate whilst all other causes of death are falling in the UK[1]. 38% of men and 16% of women (aged 16–64) misuse alcohol in England[1]. It is estimated that there are 7.1million hazardous or harmful drinkers and 1.1million dependent drinkers[2] in the UK. The East Cheshire NHS Trust was not utilising an effective patient information leaflet relating to the harmful effects of excessive alcohol consumption. Such leaflets can be vital in effective patient/public education, patient management and in aiding with altering health related behaviours.

Methods A working group was established to develop the leaflet. *Alcohol Related Disease: Meeting the Challenge of Improved Quality of care and Better Use of Resources*, produced by the BSG, was the source of much of the statistics and data used in the leaflet[1].Questionnaires were distributed and results were collated prospectively.

Results 49 questionnaires were returned. 34 female and 15 male. 53% of people reportedthey had never seen a leaflet like this before, with 63% stating that they were surprised by the extent of the