

Conclusion A negative faecal calprotectin led directly to the avoidance of a colonoscopy in 12 patients and of small bowel investigation in 11 patients. Given the trust's current tariffs for faecal calprotectin, colonoscopy and small bowel meal and follow through, a total cost saving of £7,194.59 was made. Avoiding further investigation by waiting for a negative faecal calprotectin would have resulted in a greater cost saving.

Disclosure of Interest None Declared.

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PTH-137 PATIENTS' VIEWS ON THEIR EXPERIENCE OF THE DELIVERY OF SINGLE-SEX ACCOMMODATION WITHIN THE ENDOSCOPY DEPARTMENT: IS IT WORTH IT?

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Introduction The 2007 Chief Nursing Officer's report on privacy and dignity identified provision of single-sex accommodation (SSA) as a key objective for the NHS. This was formalised in the 2010 Department of Health (DOH) policy to eliminate mixed-sex accommodation and financial sanctions for policy breaches were introduced in 2011. Our endoscopy department adopted the policy in 2011. However the unit, which opened in 2004, has only one recovery bay, necessitating separate gender lists. Urgent procedures for patients of the opposite sex to the list running are accommodated by admission/recovery in a separate endoscopy room. We explored the views of patients on their experience of attending our unit since implementation of the SSA policy. There are no published studies of patients' perspectives of care in endoscopy units since the widespread adoption of the policy in 2011.

Methods Patients attending the endoscopy unit between August and October 2012 were invited to take part in the study by nursing staff during the admission process. Patient views were assessed using a structured non-disguised questionnaire of ten closed-ended questions. The Student's *t*-test was used and a *p* value of < 0.05 was taken to be significant.

Results Of the 68 questionnaires returned (female 20, male 25, unknown 23) 14 (20.6% [80% female]) and 17 (25% [81.8% female]) reported that they would feel vulnerable changing behind a curtain or waiting in a gown in a mixed-sex area respectively. Patients ranked (scale 1–10, 1 = least, 10 = most) the importance of provision of SSA significantly lower than the importance of access to prompt investigation and treatment (mean: 4.8 [SD ± 3.74] vs 8.71 [SD ± 2.70], *p* = 2.6 × 10⁻⁷). Male patients ranked the importance of SSA significantly lower than females (mean: 1.5 [SD ± 1.05] vs 6.5 [SD ± 3.30], *p* = 6.3 × 10⁻⁶). 17/68 patients (25%) were admitted to an area other than the main receiving/recovery area because they were a different sex to the list running, and of these, 7/17 (41.2%) felt their care was compromised or patient experience reduced as a result.

Conclusion SSA delivery is important to our patients, especially women. However they rank prompt investigation and treatment as more important. The rapid introduction of SSA in our hospital, in the absence of the necessary infrastructure, conflicts in part, with the pressure to deliver timely investigations. This can lead to compromised care, notably in patients who are admitted/recovered in an alternative room and can also lead to delays for specialised endoscopy (polypectomy, ERCP and EUS). By making such compromises we are at risk of achieving no net gain in patient satisfaction and experience.

Disclosure of Interest None Declared.

PTH-138 ASSESSING THE POSITIVE PREDICTIVE VALUE OF PEPTIC ULCERATION ON ENDOSCOPY FOR THE DIAGNOSIS OF HELICOBACTER IN A GENERAL POPULATION

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Introduction Helicobacter Pylori (*H. Pylori*) is a gramme negative bacillus. It is strongly associated with peptic ulcer disease and gastric cancer. 50% of the population aged over 50 may be infected with *H. Pylori*. The prevalence in 2008 was 30–40% in the UK adult population with pockets of higher prevalence associated with deprivation. Different diagnostic tests including ¹³C urea breath test, stool antigen test, serum antibodies to *H. pylori* and rapid urease (CLO) test are commonly used in current medical practise. Histological detection of *H. Pylori* in gastric biopsy specimens still remains the gold standard investigation for diagnostic purposes. Our study was to assess whether peptic ulceration at endoscopy should be used to determine Helicobacter testing or whether all patient referred for Gastroscopy with 'non-reflux dyspepsia' should be offered testing.

Methods It was a retrospective observational study analysing results of consecutive 172 patients who had CLO test performed (male 89, female 83) on a single user operator endoscopy list over a 4 months period (March to June 2010). CLO testing was carried out on the discretion of the endoscopist on any patient with unexplained 'dyspepsia' or endoscopic findings of peptic ulceration. Data on whether patients were on a proton pump inhibitor at the time of the endoscopy or concurrent use of non-steroidal anti-inflammatory drugs (NSAIDS) was not recorded.

Results Out of 172 cases, 34 cases were tested CLO positive (12/34 CLO positive patients had evidence of peptic ulcer disease on OGD). 138 cases were tested CLO negative of which 62/138 had evidence of peptic ulcer disease. Prevalence figure in our study matched with national UK figures i.e 43.02% (95% CI: 35.51% to 50.78%).

Conclusion Approximately 1/3 of patients found to be CLO positive had signs of peptic ulceration (35%). In the same cohort of patients nearly 1/2 of patients found to be CLO negative also had signs of peptic ulceration (45%). In our study using evidence of peptic ulceration (gastritis, duodenitis, gastric and duodenal erosions/ulcers) as a guide as to whether a CLO test should be carried out is unhelpful. Caution has to be taken as we did not take into account data as to usage of PPI or NSAIDS. We suggest that presence of endoscopic findings should not be a sole determinant for Helicobacter testing.

Disclosure of Interest None Declared.

PTH-139 A UNIQUE COMBINED GASTROENTEROLOGY/RHEUMATOLOGY CLINIC: THE FIRST YEAR

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Introduction Articular problems affect many patients with inflammatory bowel disease (IBD) and joint symptoms are often difficult to control despite the therapeutic strategies aimed at controlling gut inflammation (1). Patients with inflammatory rheumatic conditions present a range of clinical problems to the gastroenterologist such as IBD, dysmotility, dysbiosis, liver dysfunction, nutritional problems and drug side effects. Patients often drift between the two specialties with inefficient communication and subsequent delay in a joined up approach to management. We therefore developed a joint gastroenterology/rheumatology clinic to improve the care of these complex patients and now report our experience of the first year.