Methods The clinic is run by a consultant gastroenterologist (GC) and consultant rheumatologist (TL) and attended by both GI and rheumatology trainees, nurse practitioners and medical students. Patients are referred from the respective specialties by consultant or SpR grade physicians. Each patient is given a 30 minute time slot which allows time for assessment, discussion, treatment planning and any therapeutic intervention such as joint aspiration/injection. Most patients are referred back to the individual specialty clinics but where necessary follow up is continued in the combined clinic. All patients attending the clinic are invited to complete a satisfaction questionnaire and give written feedback.

Results We present our experience of the first year of this innovative clinic detailing the wide range of clinical problems encountered together with anonymous patient feedback. We also present trainee, nurse and consultant perspectives on the value of the combined clinic.

Conclusion Although there are many well established combined specialty clinics we believe this is the first report of a combined gastroenterology/rheumatology clinic. The patient feedback has been very positive with all patients finding the clinic of benefit. There are many other advantages including efficiency of patient management, reducing multiple attendances to specialty clinics, learning from each other and teaching of trainees and students.

Disclosure of Interest None Declared.

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PTH-140 RISK STRATIFICATION OF UPPER GASTROINTESTINAL BLEEDING WITH THE GLASGLOW-BLATCHFORD SCORE: EXPERIENCE OF A DISTRICT GENERAL HOSPITAL IN EAST LONDON, UNITED KINGDOM

doi:10.1136/gutjnl-2013-304907.627

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Introduction The Glasgow-Blatchford Score (GBS) is a risk stratification tool to assess the need for clinical intervention to prevent death in patients with suspected upper gastrointestinal (UGI) bleeding[1]. In the UK it has been validated in four centres, with 99.6% sensitivity for not requiring endoscopic or transfusion therapy in patients with a GBS of zero[1,3]. Latest NICE guidelines recommend the GBS for risk stratification in UGI bleeds[2]. We aimed to establish whether the East London population behaved in a similar fashion to published data.

Methods The GBS was calculated retrospectively from audit data collected from patients with suspected UGI bleeding seen by the emergency department (ED) at Whipps Cross University Hospital, London between November and December 2011. During this period, clinical notes for patients with emergency department attendances coded as haematemesis, coffee-ground vomiting and/or melaena were analysed. Patients who were subsequently found to have a different diagnosis were excluded from further analysis. In addition to basic demographic and admission data, we assessed how frequently the GBS was applied. GBS scores were then correlated with endoscopy findings, and the need for endoscopic therapy at the time of endoscopy, and the need for transfusion.

Results 97 sets of notes were identified and 42 patients included in the audit, age range 26–96 (median 66 years). 61% of patients were male and 57% of admissions occurred between the hours of 0900 to 1700. In 77% of patients a GBS was not considered by emergency and/or acute medical physicians. All patients with a GBS of 0 were admitted and subsequently discharged with outpatient endoscopy.

Abstract PTH-140 Table 1

GBS	No. of Patients	UGI Pathology	Endoscopic Therapy	Blood Transfusions
0	5 (12%)	0	0	0
1–5	22 (52%)	3	0	2
6–13	15 (36%)	7	5	13

Of patients scoring 1 to 5, 11% had UGI pathology, 9% (2 patients both GBS of 5) required transfusion only. In patients scoring 6 to 13, 47% of them had UGI pathology, 33% and 87% required endoscopic therapy and blood transfusions respectively.

Conclusion UGI bleeds were most commonly found in males over the age of 65. Locally, the GBS is an underused risk stratification tool in determining the need for admission. Our preliminary data suggests patients with GBS of 0 can be discharged with outpatient endoscopy, and patients with a GBS more than 6 represent a high risk population requring emergent endoscopy. We propose that patients with a GBS of 1 or 2 can also be managed as an outpatient as our data suggest that patients in this group do not require admission. Local data suggests this can reduce patient admission rates by up to 17%.

Disclosure of Interest None Declared.

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PTH-141 COULD UPPER GI CANCER EXPLAIN FALSE POSITIVE FAECAL OCCULT BLOOD TEST (FOBT) RESULTS IN THE BOWEL CANCER SCREENING PROGRAMME?

doi:10.1136/gutjnl-2013-304907.628

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Introduction The Bowel Cancer Screening Programme (BCSP) commenced in England in 2006 using the Hemoccult guaiac faecal occult blood test (FOBt). The study aimed to evaluate if significant numbers of upper GI cancers were being diagnosed in patients with a positive FOBt in the absence of colonic pathology.

Methods A quantitative data analysis of all BCSP patients with a negative colonoscopy cross referenced with all patients within screening age (60yrs >) diagnosed with upper GI cancer in the North East of England, comprising of South of Tyne, North of Tyne, Teesside, Durham and Darlington.

Results Collectively the North East Bowel Cancer Screening centres carried out 5176 colonoscopies from 2008–2011, resulting in 1108 (21.4%) normal investigations.

In the same time period 589 patients were diagnosed with upper GI cancer. 243 were invited to participate in BCSP and 109 (45%) took part. 33/109 (30%) patients were diagnosed with upper GI cancer prior to submitting FOBt, leaving 76 (70%) presumably undiagnosed.

72/76 (94.8%) returned a negative FOBt, 2 (2.6%) returned an unclear subsequently followed by 2 negative FOBt kits according to BCSP practise, leaving 2 (2.6%) patients with a positive FOBt who subsequently had a normal colonoscopy. At the time of screening both patients were symptomatic with upper GI symptoms, and diagnosed with upper GI cancer within 3 months of screening.

Conclusion These data suggest that carrying out an upper GI investigation in FOBt positive and colonoscopy negative patients is not justified. Consideration to investigate maybe given in the