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

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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?

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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

presence of upper GI symptoms; however, further work is needed to evaluate the prevalence of upper GI symptoms in this population.
Disclosure of Interest None Declared.

PTH-142 THE ROLE OF SEHCAT SCANNING IN PATIENTS WITH CHRONIC DIARRHOEA: RESULTS FROM A NEW SERVICE

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Introduction Chronic diarrhoea is a common reason for referral to gastroenterology departments and often multiple investigations are undertaken. Bile acid malabsorption is an under recognised cause of chronic diarrhoea and currently occupies a lower tier in the investigatory pathway. SeHCaT scanning has been available in our region for the last 2 years and therefore the aim of this study was to investigate the role that this test has in such patients.
Methods All patients referred for a SeHCaT scan were identified by searching by procedure in the Nuclear Medicine department. Patient demographics, indication, number of previous tests, surgical history and SeHCaT result were noted. The cut off for an abnormal test was < 15% retention at 7 days. Notes were reviewed to determine which patients had treatment and the response rate. In those with a negative result, the final diagnosis (if known) was recorded.
Results 122 patients (95 female, median age 50 years) had undergone a SeHCaT scan for investigation of chronic diarrhoea during the period January 2011 to July 2012. 61/122 (50%) patients had a SeHCaT retention < 15% with 30 having retention values < 5%, 19 between 5.1 – 10% and 12 between 10.1 – 15%. An abnormal SeHCaT scan was associated with previous bowel surgery (Odds ratio 14.2, 95% CI 1.8–113.1, p = 0.002) but not gender (odds ratio 2.0 95% CI 0.8–4.7, p = ns) or previous cholecystectomy (odds ratio 1.2 95% CI 0.5–2.7, p = ns). 45/53 (84.9%) patients were commenced on bile acid sequestrants (mainly cholestyramine) with a good response to treatment. 13 patients were intolerant of cholestyramine and switched to colesevalam of which 10 have so far had clinical improvement. Prior to SeHCat scanning patients had undergone a median of 2.5 other investigations (range 0 – 9). Final diagnosis was bile acid diarrhoea (n = 61), irritable bowel syndrome (n = 34), malabsorption (n = 3), Crohns disease (n = 2), coeliac disease (n = 1), diverticular disease (n = 1), small bowel bacterial overgrowth (n = 1) and still being investigated (n = 19).
Conclusion In patients with chronic diarrhoea, SeHCaT scanning has a high yield and is associated with good clinical response to treatment with cholestyramine. We did not find that previous cholecystectomy was a risk factor but confirm that bowel resection appears to be. Switching to colesevalam is effective when cholestyramine is not tolerated.
Disclosure of Interest None Declared.

PTH-143 CYTOSPONGE INSTEAD OF ENDOSCOPY IN SYMPTOMATIC PATIENTS: A FEASIBILITY STUDY

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Introduction The estimated annual incidence for oesophageal adenocarcinoma in individuals with Barrett's oesophagus is 0.2–0.5%[1]. However, endoscopic screening of individuals with risk factors for Barrett's oesophagus including chronic heartburn and reflux[2] are not part of current clinical recommendations. The cytosponge, a non-endoscopic immunocytological screening kit is undergoing a multicentre study and promises to alter our current practice[3]. The cytosponge is less invasive than gastroscopy and would reduce the burden on endoscopy units if screening is to be introduced. It has also been shown to detect other benign diseases such as helicobacter, oesophagitis and candidiasis[4] and therefore may be able to replace routine gastroscopy in symptomatic patients. The aim of this study was to examine the percentage of endoscopy referrals to St Marys hospital that could be alternatively investigated with a non-endoscopic sampling method such as the cytosponge to detect Barrett's oesophagus and/or exclude more serious pathology.
Methods All pending endoscopy requests were audited on a randomly selected day. Of these, gastroscopy referrals from GP practises and outpatient department were analysed. Patients who were suitable for the cytosponge were identified using the following criteria. Inclusion - Age 45 years and above, symptoms of dyspepsia and reflux; Exclusion - Previous diagnosis of Barrett's oesophagus, previous endoscopy in the last year, portal hypertension, patients on clopidogrel or warfarin, clotting disorders.
Results A total of 161 gastroscopy referral forms were analysed; 73% from outpatients and 27% from GP surgeries. 22% of referrals were for dyspepsia and 8% for reflux. 16% of referrals were suitable for cytosponge as defined by the inclusion and exclusion criteria.
Conclusion One in six referrals from GP surgeries and outpatients could be offered cytosponge instead of endoscopy for detection of Barrett's oesophagus. Cytosponge would reduce cost, enable rapid bedside testing and provide a non-invasive method for individuals reluctant to have an endoscopic procedure. It could also be extended to detect benign oesophageal pathology and therefore avoid secondary care referrals and waiting list pressures.
Disclosure of Interest None Declared.

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PTH-144 BOWEL SCREENING IN WELSH PRISONS

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Introduction The aim of the bowel screening programme in Wales is to reduce mortality from bowel cancer by 15% in the population invited for screening by 2020. Some groups of the population are difficult to reach, particularly if they are not registered with a General Practitioner (G.P.). Not all prisoners are registered with a G.P. and a task and finish group was established to develop strategies to identify and invite prisoners for screening.
Methods Contact was made with governors and health care staff at the five prisons in Wales and an education programme provided for prison staff. Data sharing agreements were developed and agreed for each prison. Protocols and care pathways were developed for screening prisoners comprising of a slightly modified service model to the standard bowel screening programme. A pilot was established in 2 prisons and the service model modified in response to issues.

It was agreed that contact with prisoners would be through health care staff. There are around 110 prisoners within the eligible age range in Welsh prisons and during the pilot prison healthcare staff notified BSW of eligible prisoners. Invitations and test kits were sent in batches to the prisoner via the medical centre where staff arranged for prisoners to be offered the opportunity to participate.