PTH-147 AUDIT OF AN IN-PATIENT TEACHING HOSPITAL GASTROENTEROLOGY WORKLOAD IN 2012

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[1,*]H Maxwell, [1]C Smart, [1]P J Hamlin. *[1]Gastroenterology, Leeds Teaching Hospitals, Leeds, UK*

Introduction The aim of this retrospective study was to evaluate the patient demographics, route of admission, main diagnosis, duration of stay and quality of discharge summaries on the two 25 bedded gastroenterology wards at Leeds teaching hospitals NHS trust (LTHT) over a two month period. LTHT is a tertiary referral GI unit with 9 WTE consultants covering a population of 800,000. Leeds has one of six UK liver transplant units but non-transplant hepatology is covered by general gastroenterology.

Methods Patients admitted over a 2 month period on the two designated gastroenterology wards were identified from ward registers of admission. Information regarding age, gender, route of admission, main diagnosis, duration of stay and quality of the discharge summary were recorded.

Results 362 patients were identified (123 (55%) male, mean age of 54 (range of 17 to 96)). Routes of admission were 254 (70%) from the emergency department or surgical assessment unit, 43 (12%) day cases, 18 (5%) elective admissions, 18 (5%) transferred from other specialities, 15 (4%) from clinic, 7 (2%) from endoscopy and 7 (2%) unclear. The main diagnoses are listed in table 1. There were 13 deaths (4% mortality). 305 patients (91%) had discharge summaries of which 290 (95%) were completed on time. Patients who died or were transferred to other specialities were not included.

Abstract PTH-147 Table 1 Major GI diagnoses admitted over a 2-month period

Diagnosis	Number (%)	Median length of stay (range)
Liver disease	92 (25%)	3 (1–48)
Miscellaneous inc. Iron infusions	85 (23%)	2 (1–37)
GI bleeding - non variceal	63 (17%)	4 (1–33)
- variceal	8 (2%)	7 (4–31)
Inflammatory bowel disease	36 (10%)	6 (1–20)
Medical outliers	32 (9%)	5 (1–47)
GI oncology	14 (4%)	8 (1–20)
Pancreaticobiliary	9 (2%)	10 (4–13)
Nutrition (TPN, PEG insertion)	4 (1%)	16 (2–28)
Incomplete discharge summary	19 (5%)	

Conclusion These data demonstrate the caseload mix admitted to a tertiary referral GI unit. 25% of admissions were for liver disease in addition to the service provided by the transplant unit. This reflects the national problem of the increasing burden of liver disease to the NHS. Understanding the case mix facilitates service development in line with the population needs and BSG recommendations such as alcohol teams, GI bleeding rotas and the IBD service standards. A significant proportion of miscellaneous admissions were for day case infusions which may be more appropriately delivered away from the acute bed base. The unit is striving for 100% timely and fully complete eDANs.

Disclosure of Interest None Declared.

PTH-148 DOES GLASGOW BLATCHFORD SCORE OR PRE-ENDOSCOPY ROCKALL SCORE IDENTIFY LOW RISK PATIENTS FOLLOWING UPPER GASTROINTESTINAL HAEMORRHAGE? A NEW ZEALAND PERSPECTIVE

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[1,2,*]I A Murray, [3]M R Johnston, [3]H Leung, [3]H Norton, [3]J-Y Park, [3]T Fesaitu, [3]C Baines, [3]E Fawcett, [3]A Salleh, [3]P McLeod, [3]N R O'Donnell, [4]W Zhang, [5]J A García, [1,3]M Schultz. *[1]Gastroenterology, Dunedin Hospital, Dunedin, New Zealand; [2]Gastroenterology, Royal Cornwall Hospital, Truro, UK; [3]Dunedin School of Medicine, University of Otago, Dunedin; [4]Dunedin School of Medicine, University of Otago, Truro; [5]Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand*

Introduction Upper gastrointestinal haemorrhage (UGIH) is a common medical emergency worldwide. The Glasgow Blatchford (GBS) and pre-endoscopy Rockall (PERS) scores are used to predict outcome and need for intervention. This retrospective study aims to determine their value in a mixed rural and urban population in New Zealand.

Methods GBS and PERS were determined for all adult patients admitted with UGIH to our teaching hospital between January 2007 and November 2011. Need for therapy (endoscopic, blood transfusion or surgery), 30-day mortality and 14-day re-bleed rate were recorded and the optimum scoring system for predicting low risk patients determined by logistic regression. The Lower South Regional Ethics Committee approved the study.

Results There were 424 admissions with UGIH: data was complete for 388 admissions to enable PERS and GBS calculation. Median age was 74.3 years, 55.1% were male and the majority were New Zealand European (85.8%). Commonest findings were oesophagitis, gastritis, duodenitis (43%), peptic ulcer (35.3%), hiatus hernia (16.8%), normal (11.9%), varices (4.8%) and malignancy (3.1%). 181 cases (46.6%) received an intervention, of which 75 (19.3%) had an endoscopic intervention, 147 (37.9%) a blood transfusion, 8 (2.1%) surgery and 7 (1.8%) an iron infusion. 30-day mortality was 4.6% (18 patients) and 14-day re-bleed rate was 6.0% (23 patients). GBS < 1 predicted low risk (no intervention, re-bleed or mortality), accounting for only 3.1% of all admissions (14 patients). 42 (10.8%) had a PERS of 0 but intervention was required in 15 (35.7%). A further 193 patients had outpatient gastroscopy for UGIH and 113 had inpatient bleeds during the study period.

Abstract PTH-148 Table 1 Outcomes and Interventions for 388 patients admitted with upper gastrointestinal haemorrhage over 5 years (2006–2011).

		Number of Cases	Percentage of Total (n)
Outcomes	Intervention required	181	46.6%
	Death within 30 days	18	4.64%
	Rebleeding within 14 days	23	5.93%
Interventions	Blood transfusion	147	37.9%
	Endoscopic intervention	75 (56 injection, 16 endoclip, 5 banding, 3 APC)	19.3%
	Surgery	8	2.06%

Conclusion GBS (of < 1) is superior to PERS in identifying low risk patients who could be safely managed as outpatients following UGIH saving health resources. Despite having less patients with varices we had fewer low risk patients than British studies. Low risk patients may have been triaged to outpatient endoscopy by Primary Care.

Disclosure of Interest None Declared.

PTH-149 SUCCESSFUL CARE FOR PATIENTS WITH CHRONIC HEPATITIS B VIRUS INFECTION IN A DEDICATED DRUG AND ALCOHOL ADDICTION SERVICE IN EAST LONDON

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[1,*]J Kunkel, [2]M Wilkinson, [1]G R Foster. *[1]Hepatology, Centre for Digestive Diseases, Blizard Institute, Queen Mary, University of London; [2]Blood Borne Virus Team, Tower Hamlets Specialist Addiction Unit, London, UK*

Introduction Chronic Hepatitis B Virus (HBV) infection in persons attending drug addiction services has not been studied as