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

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

thoroughly as infection with Hepatitis C Virus (HCV). The aim of this audit was to assess the number of service users chronically infected with HBV and their relevant co-infections, co-morbidities and access to treatment.

Methods The Tower Hamlets Specialist Addiction Unit serves the London Borough of Tower Hamlets with a population of more than 200,000. Its Blood Borne Virus Team (BBVT) provides harm reduction healthcare in more than 10 drug and alcohol addiction facilities including outreach sites and neighbouring boroughs. Data on service users chronically infected with HBV was extracted from the service database.

Results Of 2577 people currently registered with the BBVT 49 (1.9%) have chronic HBV infection with detectable HBs-Antigen. 88% are male, the average age is 40 years and the majority is of non-British origin with large groups of Baltic (18%) and Black/African/Caribbean (20%) ethnicity. 16 patients (33%) are currently injecting drug users (IDU), 13 (27%) formerly IDU. Other reasons for referral are non-injecting drug and alcohol use. 14/49 patients (29%) have psychiatric comorbidities other than drug/alcohol abuse. 22 patients (45%) knew about their infection when they entered the service.

12 patients (24%) have HBe-Antigen-positive and 37 (76%) HBe-Antigen-negative disease. 12/49 patients (24%) have detectable HCV-RNA and can be regarded as co-infected. 3/49 patients (6%) have detectable Hepatitis D Virus (HDV)-RNA. Two patients (4%) are infected with HBV, HCV and HDV. Two patients (4%) have active syphilis co-infection and HIV-co-infection, respectively.

10/49 patients (20%) have been diagnosed with cirrhosis. One patient has undergone resection for HBV-associated hepatocellular carcinoma and has been followed up for 9 years without recurrence. Two patients were infected after documented vaccination against HBV. 7/49 patients (14%) are currently undergoing treatment with a regimen that is effective against HBV. Three patients have cleared HBV, one through treatment and two spontaneously.

Conclusion Even in a difficult setting where care can be interrupted by incarceration or psychiatric deterioration, successful health care for patients with chronic HBV infection is possible by using outreach facilities and appointment reminders. The community attending drug addiction services has overlapping risk factors and in East London, only a minority of patients chronically infected with HBV are currently injecting drug users. Vaccination against HBV has no 100% protection rate and service users should repeatedly undergo testing for blood borne viruses.

Disclosure of Interest None Declared.

PTH-150 BENEFITS OF A LIVER TRANSPLANT OUTREACH CLINIC: INCREASED REFERRALS AND PATIENT SATISFACTION

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Introduction The current landscape of service provision for patients with liver disease does not match that of disease burden[1]. Most hepatologists are based in transplant centres and access to tertiary liver services is not geographically equitable[1]. In an attempt to improve access, we established a liver transplant outreach clinic from the regional liver unit within a large gastroenterology unit. Here, we describe the benefits of this clinic.

Methods A dedicated monthly joint liver clinic was established in a large gastroenterology unit. Patients with complex liver disease, including pre- and post-transplant are seen by a consultant transplant hepatologist from the regional liver unit (SM) and a local consultant gastroenterologist (AD). Quantitative data was available from the transplant centre. A sample of patients and specialists were asked to complete a written questionnaire on their opinions of the clinic service.

Results Since August 2010, over 400 patients have been seen. In the 4 years prior to the establishment of the clinic, there were a median of 3 (1–4) referrals annually for liver transplant assessment. This increased to 9.5 (9–10) in the subsequent 2 years. Patients were satisfied with the clinical service (Table 1) and the majority (95%) preferred local follow up, citing it as more convenient (100%) with easier travel arrangements (100%). Specialists (n = 16) agreed unanimously that the clinic was more convenient for patients, easy to refer into and improved both accessibility to liver services and communication with the regional liver unit. Most (83%) felt that it reduced waiting times for specialist opinion.

Abstract PTH-150 Table 1 Patient questions and mean score 1 (low) – 5 (high)

Patient Question	Mean Score
Overall quality of care and services	4.5
Access to specialty care, if needed	4.4
Skill, experience and training of doctors	4.6
Respect shown to you by doctors	4.8
Confidence in the doctor you saw	4.7

Conclusion Establishing an outreach clinic has increased referrals for transplant assessment. Patients prefer to be seen locally and do not feel this affects their specialist care. They have confidence in the skill and experience of the clinicians they see and rate the quality of care, highly. Referring clinicians are also satisfied with the quality and accessibility of the outreach clinic. Overall, outreach clinics may serve to improve equity of access to transplant services.

Disclosure of Interest None Declared.

REFERENCE

1. Liver Disease Patient Landscape and Care Provision, 2011, http://www.liver.nhs.uk/publications/accessed 14th Jan 2013

PTH-151 THE IMPLICATIONS FOR NEW TO FOLLOW-UP RATIOS BASED ON DIAGNOSES ENCOUNTERED IN GASTROENTEROLOGY OUTPATIENT SERVICES

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Introduction 'Better Care, Better Values' highlighted the importance of outpatient new to follow up ratios (NFRs) (1). Trusts are encouraged to reduce NFRs or may perform unpaid activity. This has implications for patient care, yet can conflict with Speciality guidelines for follow up. There are no published data on the diagnostic case-mix attending secondary care Gastroenterology appointments nor are any diagnostic data available from Hospital Episode Statistics (HES) for outpatient-based specialties.

Methods We performed a retrospective audit of all Gastroenterology follow-up patients attending Wirral University Teaching Hospital (catchment population 360,000) during a 3-month period. All clinic letters were identified from the hospital IT system and the following information obtained.

- Number of new and follow up attendances per Consultant-led clinic
- Primary diagnosis for each follow-up encounter
- Appointment outcome- further follow up or discharge
- Discharge rate per diagnosis
- Number seen in dedicated Specialist Nurse clinics