**Disclosure of Interest** None Declared.

**REFERENCE**

1. Impact of a nurse-led telephone clinic on quality of IBD care Sharon Gethins *et al.* Gastrointestinal Nursing, Vol. 5, Iss. 1, 18 Jan 2007, pp 34 – 39

## PTH-154 THE OUTPATIENT BURDEN OF INFLAMMATORY BOWEL DISEASE: A 10 YEAR REVIEW

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**Introduction** Like many hospitals through out the UK the National IBD Standards (endorsed by the British Society of Gastroenterology) and the IBD (Global Rating Score) Quality Improvement Programme (endorsed by The Royal College of Physicians) have help highlighted areas of our inflammatory bowel disease (IBD) service that clearly need improving. In order to attract funding from our local primary care trust (PCT) to support the necessary service improvements, we set about establishing the total cost and demand made on our local hospital in managing these patients. We set about assessing 4 key areas; the endoscopy service, the radiology service, the hospital admissions and the outpatient service.

**Objective** of this study: To assess the demand on the outpatient services made by IBD patients.

**Methods** The Luton & Dunstable University Hospital has a database of 2680 local IBD patients. This is made up of 1425 patients with UC, 941 with Crohn's, 118 with proctitis, 113 with IBD unspecified, 53 with radiation proctitis, 13 with diversion colitis, 10 with ileo-anal pouchitis and 7 with microscopic colitis. Using the database the hospital coding system was used to analyse the total number of outpatient appointments (OPAs) made between 2001 and 2011 for these patients, and to which specialties they were referred. Total costs were calculated using a range of prices for the different specialties, depending on whether they were new (£210-£265) or follow up clinic visits (£83-£136).

**Results** Over the course of 10 years the 2680 IBD patients made 20,837 gastroenterology OPAs (2,053 new and 18,784 follow ups) (ie.2,084 per year), costing the local primary care trust (PCT) a total of £2,103,117. There were also 3474 OPAs made with the gastrointestinal (GI) surgeons (1,409 new and 2,065 follow ups) (ie. 347 per year), costing the local PCT a total of £603,524. In addition a further 42,276 (63%) OPAs were made with non-GI teams, costing the PCT an further £4,227,600.

**Conclusion** Over 10 years the 2680 patients made 66,007 outpatient clinic visits (24.6 per person, 2.46 per person per year) costings a total of £6,934,241. Of these, 24,311 (37%) were with the GI medics and surgeons, costing the PCT a total of £2,706,641. Many of the non-GI specialty appointments were made for IBD associated conditions eg. 1510 dermatology OPAs. The 3281 ophthalmology OPAs were predominantly for cataracts, which raised concerns about potential iatrogenic causes.

**Disclosure of Interest** None Declared.

## PTH-155 THE HOSPITAL ADMISSION BURDEN OF INFLAMMATORY BOWEL DISEASE: A 10 YEAR REVIEW FROM A DISTRICT GENERAL HOSPITAL

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**Introduction** The National IBD Standards and IBD (Global Rating Score) Quality Improvement Programme have highlighted areas of our inflammatory bowel disease (IBD) service that need funding, in order to make the neccessary improvements. To facilitate this we set about establishing the total cost and demand of managing IBD patients in our local hospital, reviewing 4 key areas; the endoscopy, radiology, outpatients and hospital admissions services.

Study Objectives: To assess the average length of stay (LOS) and total number of hospital admissions made by IBD patients over 10y.

**Methods** The Luton & Dunstable University Hospital has a database of 2680 local IBD patients. This is made up of 1425 patients with UC, 941 with Crohn's, 118 with proctitis, 113 with IBD unspecified, 53 with radiation proctitis, 13 with diversion colitis, 10 with ileo-anal pouchitis and 7 with microscopic colitis. Using this database the hospital coding system was used to analyse the total number of hospital admissions made between 2001 and 2011 for these patients, and to which specialties they were being admitted.

**Results** Over the course of 10 years the 2680 IBD patients made a total of 6385 hospital admissions. Of these, UC patients accounted for 2524 admissions, whilst the Crohn's patients had a proportionally higher admission rate, accounting for 2504 admissions. The number of admissions per patient ranged from 1 to 134, and of those admitted they had a mean of 6.4 admissions each. These patients were being admitted by a range of specialties including 4361 by general medicine, 1260 by general surgery, 251 by elderly care, 103 by paediatrics, 101 by orthopaedics, 66 by urology, 29 by the ears, nose and throat team, 45 by obstetrics and gynaecology, 11 by medical oncology, 48 by haematology, 5 obstetrics, 32 by ophthalmology, 43 by the maxillary facial team, 4 by A+E, 1 by anaesthetic pain relief team, 24 by cardiology and 1 by dermatology. The type of admission ranged from being elective/planned admissions in 4457, A+E emergency admissions in 1,363, emergency admission from clinic in 116, emergency GP admissions in 420, and 9 patients transfers from other hospitals.

**Conclusion** Over the 10 year period 1724/2680 (64%) of all the IBD patients required at least 1 hospital admission. On average this cohort of patients required a mean of 2.4 hospital admissions, with Crohn's disease patients placing a greater demand on the hospital admission services (average = 2.66 admissions) as compared with the UC patients (average = 1.77). The average length of stay was 2.6 days (range = 1–278 days). Whilst it is clear that not all the hospital admissions were directly related to the underlying IBD, it is clear that there is a heavy demand placed on the local hospital admission services from this cohort of IBD patients.

**Disclosure of Interest** None Declared.

## PTH-156 INFLAMMATORY BOWEL DISEASE: A 10 YEAR REVIEW OF THE COST AND DEMAND OF THIS CONDITION, ON A DISTRICT GENERAL ENDOSCOPY UNIT

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**Introduction** Like many hospitals through out the UK, the National IBD Standards (endorsed by the British Society of Gastroenterology) and the IBD (Global Rating Score) Quality Improvement Programme (endorsed by The Royal College of Physicians) have help highlighted areas of our inflammatory bowel disease (IBD) service that needed improving. In order to attract funding from our local primary care trust (PCT) to support the necessary service improvements, we set about establishing the total cost and demand made by this cohort of patients on 4 key services offered by our local hospital; the endoscopy, radiology, hospital admissions and outpatient services.

**Objectives** of this study: To assess the cost and demand for endoscopy originating from the management of IBD patients, over a 10 year period.

**Methods** The Luton & Dunstable University Hospital has a database of 2680 local IBD patients. This is made up of 1425 patients with UC, 941 with Crohn's, 118 with proctitis, 113 with IBD

unspecified, 53 with radiation proctitis, 13 with diversion colitis, 10 with ileo-anal pouchitis and 7 with microscopic colitis. Using the database for reference, the hospital coding system was used to analyse the total number of lower gastrointestinal endoscopy procedures performed between 2001 and 2011 on IBD patients. The total cost for the primary care trust (PCT) was then calculated based on the Department of Health National Tariff System, awarding £561 for a diagnostic colonoscopy and £482 for a flexible sigmoidoscopy.

**Results** Over the 10 year period, the 2680 patients underwent 1835 flexible sigmoidoscopies (1405 in UC patients, 134 in Crohn's patients and in 296 patients with IBD unspecified) and 1475 colonoscopies (780 in UC patients, 436 in Crohn's patients and in 259 patients with IBD unspecified). In total this cost the PCT £884,470 for flexible sigmoidoscopy and £827,475 for colonoscopy.

**Conclusion** Over the course of 10 years the 2680 IBD patients had a total of 3328 lower GI endoscopies (or 332 per year). This cost the local PCT a total of £1,711,945 (or £171,194 per year). A greater utilisation of faecal calprotectin for the assessment of disease activity and treatment monitoring in IBD may help reduce the total number and cost of lower GI endoscopy in this cohort of patients.

**Disclosure of Interest** None Declared.

## PTH-157 THE USE OF A FAECAL CALPROTECTIN IN ROUTINE CLINICAL PRACTICE CAN HELP AVOID DILEMA AND SIGNIFICANTLY REDUCE UNNECESSARY COLONOSCOPY

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**Introduction** The new faecal calprotectin (FC) assessment kits are capable of differentiating between organic and functional bowel disease with a 93% sensitivity and 96% specificity (Rheenen. BMJ.2010). Where the diagnosis is unclear, FC can be used to spare unnecessary invasive colonoscopy. Functional (Irritable bowel syndrome - IBS) symptoms occur in 60% of ulcerative colitis (UC) and 40% of Crohn's disease patients (Keohane. AJG. 2010). This can cause a notoriously difficult management dilemma, which in turn can lead to over treatment of presumed flares in the inflammatory bowel disease (IBD).

**Objectives** 1) To assess the ability of FC in differentiating between functional and organic disease where the diagnosis was uncertain, and to review the number of potentially unnecessary colonoscopies that could be spared. 2) To assess the management outcome in symptomatic IBD patients when using FC to determine IBS from inflammatory symptoms.

**Methods** Over a 6month period FC data was collected from both new gastroenterology referral patients and known IBD patients, where a colonoscopy was being considered because of diagnostic uncertainty about whether they were suffering from organic or functional (IBS) symptoms. A retrospective review was them performed to assess the diagnostic and management outcome.

**Results** In total 100 FC assessments were performed in new referral patients and 44 in known IBD patients where there had been a diagnostic dilemma. In the new patients colonoscopy was spared in 70% (70/100), including 55/63 with normal FC (< 60), 6/7 with borderline FC (60–100), and 9/30 with high FC (> 100). Some of these patients did however opt for a CT cologram were positive findings were seen in 0/6 of those with normal FC, 1/2 (1 diverticular disease) with borderline FC, and 7 (2 normal, 4 diverticular disease, 1 cancer) with high FC. Despite normal FC results 6 new patients went on to have a colonoscopy, 5 of which were normal and 1 demonstrated a low grade dysplastic tubular adenoma. In the IBD patients colonoscopy was spared in 84% (37/44), including 13/14 with normal FC, 8/9 with borderline FC and 16/21 with high FC. In the IBD cohort the FC changed management in 10/14 with normal results, 4/9 with borderline results and 16/21 with high results.

**Conclusion** With the increasing demand being made on colonoscopy throughout UK, a greater utilisation of faecal calprotectin into clinical practise could help safely relieve some of this burden. Faecal calprotectin can be strongly influential in the management of known IBD patients, and provides confidence for clinicians to focus in on treating functional bowel symptoms and tailor down escalating management regimes in those with normal results.

**Disclosure of Interest** None Declared.

## PTH-158 ALCOHOL IN-PATIENT DETOX: WITHDRAWING THE BURDEN OF IN PATIENT MANAGEMENT

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**Introduction** In 2009–10, there were 1,057,000 alcohol related admissions to a hospitals in England[1]. Currently patients treatmented for alcohol withdrawal require hospital admission for at least 4–7 days, to complete medical detoxification. Previous studies have shown that even those patients who have severe symptoms of withdrawal, after 2–3 days, can be safely treated in an ambulatory environment[2].

**The Aim** of this study was to identify the current burden of acute alcohol admissions to the medical unit, demographics of patients and the cost effectiveness of integrating an ambulatory care system.

**Methods** Retrospective data from six months of accident and emergency (A&E) admissions were reviewed from January 2012-June 2012. Patients admitted with acute alcohol intoxication or withdrawal were identified and patients notes analysed. Costings for management were estimated using data sourced from Department of Health Reference Costs 2011–12.

**Results** Of the 203 patients presenting to A&E with acute alcohol intoxication or withdrawal, 51 patients were treated for acute alcohol withdrawal (22 female, 29 male). The average age of patients was 60 years. 43% of patients were managed by acute assessment teams, 31% by gastroenterology, and 25% by general medicine. 2 patients required management in ITU. Mean length of stay 10.4 days. Of the patients reviewed the mean drinking years 8.03 with an average of 165 units of alcohol drunk per week.

50% of patients had with a documented mental health assessment, of which 74% had documented mental health conditions other than alcohol dependency. Mortality over this period was 0.1% and readmission within the six month period was averaged at 2.9 admissions.

Cost of current 7 seven day inpatient admission with 4 hours of junior doctor input was costed at £2183.47 vs a three day admission with 3 three follow up ambulatory appointments and 2 two hours of junior doctor time costing £1352.57.

**Conclusion** The burden of alcohol related admissions requires an innovative approach to improve patient care and reduce readmissions. Our study has highlighted the possibility of utilising ambulatory care in selected patients as a method of improving care and reducing the cost of admissions to hospital. It also highlighted the importance of identifying patients as high risk of mental health issues. Previous work has identifed the benefits of outpatient withdrawal in abstenence and psychological well being[3]. Subsequent to this study our hospital has piloted an ambulatory care pathway and prospective analysis will be completed in due course.

**Disclosure of Interest** None Declared.

### REFERENCES

1. www.ic.nhs.uk/pubs/alcohol12
2. Stockwell *et al.* Home detoxification from alcohol: its safety and efficacy in comparison with in-patient care. ALcohol and ALcoholism 26. 645–650
3. Fleeman *et al.* Alcohol home detoxification: A literature review. Alcohol and Alcoholism 32. 649–656