

strikingly, 65% of the doctors surveyed did not consider starting enteral feed prior to or alongside correcting any electrolyte imbalances. Delaying the onset of enteral feed may put patients at greater risk of malnutrition. Further education and training about RS are necessary for all grades, particularly junior doctors.

Disclosure of Interest None Declared

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PTU-002 LARGE VOLUME PARACENTESIS (LVP) CAN BE SAFELY PERFORMED BY JUNIOR DOCTORS WITHOUT ULTRASOUND GUIDANCE

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¹B Conduit, ¹E Wesley, ¹J Christie, ¹U Thalheimer. *Gastroenterology, Royal Devon and Exeter Hospital, Exeter, UK*

Introduction The introduction of the European Working Time Directive has led to concerns about reduction in exposure to practical procedures for junior doctors¹.

Ultrasound is now considered essential for pleural aspiration and chest drain insertion². Its use for LVP has also been suggested³.

Our aim was to assess the safety of LVP performed at our centre according to the clinical grade of the operator.

Methods We identified patients who had undergone LVP at our hospital during a 12 month period from October 2010 by reviewing the admission book of our department and by reviewing a list of all the ascitic fluid samples sent to our microbiology department. Case notes for these patients were reviewed and data were collected on patient demographics, method of insertion (blind vs. ultrasound guided), grade of operator, adequacy of albumin replacement and the occurrence of any complications.

Results 56 LVP were performed on 28 patients.

53 drains were successfully inserted blindly, 3 required ultrasound guidance.

2 drains were inserted by consultants (both ultrasound guided) and 9 by registrars. 15 were inserted by core training doctors (1 procedure was supervised) and 28 by foundation doctors (19 supervised).

Ascites was sent for white cell count after 53 (95%) procedures.

No major procedure related complications occurred; 1 patient required a stitch for a minor cutaneous bleed after drain removal.

6 received < 6g albumin per litre of ascites drained. 3 LVP were carried out with no albumin replacement, in 2 of these the drain had been inserted under ultrasound guidance. For 2 procedures (performed on surgical wards) the drain was not removed after 6 hours.

Conclusion LVP can be safely performed without ultrasound guidance by adequately trained or supervised junior doctors. Some failings occurred with regard to albumin replacement, timely drain removal and request for ascitic white cell count. However, none of these would have been prevented by performing drain insertion under ultrasound guidance. Patients who had their drain inserted under ultrasound guidance were in fact more likely to receive sub-optimal post-procedure care.

Protocols are required for the management of ascitic drains and clear communication with nursing staff is essential.

Disclosure of Interest None Declared

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PTU-003 PARACENTESIS: UK TRAINEES' PRACTICE, EXPERIENCE AND ATTITUDES

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¹C Shekhar, ¹A Ramakrishnan, ²L C Claridge. *Gastroenterology, University Hospital of North Staffordshire, Stoke on Trent; ²Liver Unit, St James's University Hospital, Leeds, UK*

Introduction Abdominal paracentesis is considered a relatively safe procedure¹ but serious life threatening complications are known to occur² and practise guidelines often differ between centres. Moreover, in many European countries gastroenterologists are trained in the use of abdominal ultrasound and utilise this when inserting paracentesis catheters.

Aim :To obtain a snapshot of current UK trainee practise and experience of paracentesis and its complications.

Methods A cross sectional survey of current UK gastroenterology trainees was conducted over a 3 week period (Dec 2012-Jan 2013).

Results 88 trainees completed the survey. 75% (76/88) of respondents have more than 3 yrs' experience in gastroenterology at registrar level. 42% (37/88) report having performed or supervised > 100 procedures and a further 42% have performed > 50 procedures. 28.7% (26/88) have witnessed serious complications; 14.9% (13/88) report significant haemorrhage requiring blood transfusion, 16.1% (14/88) have encountered bowel perforation and 9%(6/88) attribute a patient's death to a paracentesis. Only 10.2% (9/88) of trainees routinely take informed written consent. 22.7% (20/88) state that their unit has no formal consent policy for paracentesis. 63% (48/88) of trainees exclusively use suprapubic 'Bonnano' catheters despite the fact that this product is unlicensed for use as a paracentesis catheter.

The majority of trainees (78.4%) estimate a failure rate requiring ultrasound guided catheter placement of < 10%. However, 23.9% (21/88) state that when this is required patients routinely wait longer than 2 days. 73.9% (65/88) report that radiology colleagues are unwilling to insert catheters in patients with INR > 1.5 without administration of fresh frozen plasma. 80.7% (71/88) of trainees believe training in abdominal ultrasonography should be part of the gastroenterology curriculum and 62.5% (55/88) feel that this would improve the safety and efficiency of paracentesis.

Conclusion The number of UK trainees reporting serious adverse events due to paracentesis is higher than expected. It is therefore of concern that few trainees are taking written consent for this procedure. The majority of trainees are still using the unlicensed 'Bonnano' catheter despite the availability of licenced products such as the 'Safe-T-Centesis' and 'Neo-Hydro' drainage kits. The majority of UK gastroenterology trainees express a desire to be trained in abdominal ultrasonography and believe this would improve the safety of paracentesis.

Disclosure of Interest None Declared

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PTU-004 THE USE OF A "MOODLE" VIRTUAL LEARNING ENVIRONMENT (VLE) IN GASTROENTEROLOGY TRAINING

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¹D Rogers, ¹T Delahooke. *University Hospitals of Leicester, Leicester, UK*

Introduction The East Midlands Healthcare Workforce Deanery launched a VLE pilot in 2009 and subsequently rolled out the "Moodle" based platform to all Postgraduate schools. Some schools have used the VLE as an information repository only, but The School of Gastroenterology South was keen to exploit the full potential by developing interactive activities and evaluating their acceptability to trainees.