

with elevated serum amylase went on to notes review, of whom 36 (20 female, mean age 61) were determined to have clinical pancreatitis i.e. 1.3% of all patients undergoing ERCP. Of those with pancreatitis, 4 procedures had a complexity grading of Level 1, 27 of level 2, and 1 case of level 3. In 4 cases the endoscopist was unable to cannulate the CBD. None of the patients received prophylactic NSAIDs at the time of procedure. 3 patients required ITU admission and there were 2 deaths. In 14 cases of PEP (39%), risk factors were present that could be considered an indication for prophylactic stenting, i.e. 0.52% of all patients undergoing ERCP.

Conclusion 2699 ERCP procedures were performed, no prophylactic stents were placed, but pancreatitis occurred as a complication in only 1.3% of procedures. Fewer than half of these patients would have been considered candidates for pancreatic stenting if available. With such a low baseline rate of PEP, the introduction of pancreatic stents should be appropriately selective in high-risk patients only, and NSAIDs considered in all high-risk patients without contraindications.

REFERENCE

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Disclosure of Interest None Declared.

Gastroenterology service: development, delivery, IT

PTH-016 DIAGNOSIS AND MANAGEMENT OF SPONTANEOUS BACTERIAL PERITONITIS: IS THERE A NEED FOR AN URGENT UPDATE OF NATIONAL GUIDELINES?

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Introduction Spontaneous Bacterial Peritonitis (SBP) is a frequent and serious complication in cirrhotic patients with ascitis. Clinical guidelines have been published by the BSG, EASL and AASLD for the diagnosis and management of SBP. We carried out a survey of current practice in the diagnosis and management of SBP in the North West of England.

Methods Survey questionnaires were sent to the Hepatology leads of NHS hospital trusts in the North West of England.

Results 11 responses from a total of 18 hospitals are included in this analysis. Ascitic fluid total white cell count (WCC) is estimated in all hospitals but only 6 (54.5%) estimate neutrophil count in addition. However only 5 trusts out of these 6 base the diagnosis of SBP on neutrophil count $> 250 /\text{mm}^3$ ($0.25 \times 10^9 /\text{L}$) which is in line with the recommendations of the above guidelines. Remaining use WCC $> 250 /\text{mm}^3$ ($0.25 \times 10^9 /\text{L}$) as the criteria to diagnose SBP. Bedside inoculation of ascitic fluid for culture and sensitivity is practiced in most hospitals (10 of 11, 90.9%). First line antibiotic regimes used are listed in Table 1.

All hospitals offer secondary prophylaxis, ciprofloxacin being the most commonly used (8/11, 72.7%). Septrin 960 mg o.d. is recommended in 2 hospitals (18.2%) and a choice of ciprofloxacin, septrin or rifaximin in another. The dose of ciprofloxacin used was also varied – 500 mgs o.d. in 6 hospitals (75%), 250 mgs o.d. in 1 (12.5%) and 250 mgs weekly in 1 hospital (12.5%).

Primary prophylaxis is offered in only 2 hospitals (18.2%) based on ascitic fluid albumin concentration of $< 20 \text{ g/L}$ in one or $< 10 \text{ g/L}$ in those patients awaiting orthotopic liver transplant with no prior history of clostridium difficile infection in the other hospital.

Conclusion There is wide variation in practice in hospitals in the North West of England despite national and international guidelines. Varied criteria are used to diagnose SBP with fewer hospitals using ascitic neutrophil count which may lead to over-diagnosis and over use of antibiotics. There is a trend towards using tazocin and augmentin as first line antibiotics in the management of SBP even though the evidence is currently unclear. This probably reflects the underlying fear of Clostridium difficile infection associated with the use of quinolones and cephalosporins. Septrin is sparsely used for secondary prophylaxis despite being the preferred antibiotic of choice in regional liver transplant centre. An update of national guidelines regarding management of SBP including primary prophylaxis is urgently required.

Disclosure of Interest None Declared.

PTH-017 INVESTIGATIONS, CANCER DIAGNOSES AND COST: A PROSPECTIVE STUDY OF TWO WEEK RULE VERSUS NON-TWO WEEK RULE GASTROENTEROLOGY REFERRALS AT A DISTRICT GENERAL HOSPITAL

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Introduction In 2000, the UK government introduced the two-week rule (TWR) referral initiative. This was to ensure all patients with symptoms potentially indicating a diagnosis of cancer were seen by a relevant specialist within two weeks of referral by their GP. Since its initiation, very little data has indicated improved survival outcomes for patients diagnosed with cancer via this pathway.

Methods All patients referred to gastroenterology under Two Week Rule (TWR) and standard non-Two Week Rule (non-TWR) pathways were prospectively followed up for a 3 month period from date of referral. This was done covertly by the investigators to avoid influencing decision making by the clinic physicians. Data recorded included number of clinic visits, number and type of radiological/endoscopic investigations undertaken, end diagnosis and cancer diagnosis. Crude costs per patient were calculated using the hospital's unit costing database.

Results There were 52 TWR patients (mean age 72.5, male 48.1%) and 89 non-TWR patients (mean age 57.9 ($p = 0.0001$),

Abstract PTH-016 Table 2 Recommended first line antibiotic for Treatment of SBP (number of hospitals, percentage)

	Tazocin	Augmentin	Ceftriaxone	Cefuroxime	Ciprofloxacin	No answer
Intravenous	5, 45.5%	2, 18.2%	2, 18.2%	2, 18.2%	0	0
Oral	0	4, 36.4%	0	0	3, 27.3%	4, 36.4%