

Abstract PTH-017 Table 1

Reason for referral	Anaemia	Abdominal pain	Abnormal LFTs	Weight loss	Vomiting or Dysphagia	Abnormal tests or imaging	Change in bowel habit	PR bleeding
TWR (%)	17.3	9.3	3.8	19.2	26.9	7.7	7.7	7.7
Non-TWR (%)	6.7	33.7	10.1	0.0	15.7	14.6	14.6	4.5

male 36.0%). Reason for referral for TWR/non-TWR is shown in the table below:

76.9% of TWR patients had an endoscopic procedure compared to 62.9% of non TWR patients ($p = 0.09$). A similar percentage of patients in both groups underwent radiological investigation (TWR: 53.85%, non-TWR: 50.56%). More TWR patients underwent second imaging than non-TWR (9.6% vs. 6.7). 7.7% of TWR patients and 3.4% of non TWR patients had an end diagnosis of cancer, although this difference did not reach statistical significance. The mean age of the cancer patients in the TWR and non-TWR group was 70.3 years and 66.3 years respectively (although 2 of these in the non-TWR were below 65). 23.1 and 19.1% of patients had no clear diagnosis at 3 months in the TWR and non-TWR respectively. The mean cost of investigations and follow-up was significantly higher in the TWR cohort (£754.1 vs £613.1, $p = 0.04$).

Conclusion In our sample of patients, those referred under the TWR pathway underwent a higher burden of invasive investigation with no significant increase in cancer pick up, despite being significantly more costly. The current system possibly delays cancer diagnoses in younger patients, who are more likely to be filtered through the non-TWR pathway. Perhaps alternative referral pathways need to be considered in a bid to improve cancer diagnosis in high risk patients.

Disclosure of Interest None Declared.

PTH-018 INTRAVENOUS FERRIC CARBOXYMALTOS (FERINJECT) GIVEN TO PATIENTS POST ENDOSCOPY – SAFE AND COST EFFECTIVE

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Introduction Intravenous (IV) iron is established as an effective management for patients with iron deficiency anaemia (IDA) and is indicated in those with severe iron deficiency, malabsorption, intolerance to oral iron and/or those requiring rapid correction of IDA.¹

The use of traditional agents iron dextran (CosmoFer) and iron sucrose (Venofer) are inexpensive in drug cost (£50–60), however they require test doses, slow intravenous infusions (4 h +) and the incidence of hypersensitivity reactions are high. This required a day case attendance which increased the overall cost of an infusion significantly.

Then introduction of Ferric Carboxymaltose (FCM) has changed the landscape. Whilst the drug cost is 4 times higher, infusions only take 15 min and are much better tolerated. Also a higher dose of 1 g can be given. This only requires a short hospital appointment and reduces the overall cost of an infusion to less than traditional agents.

The majority of patients with IDA undergo endoscopy for investigation +/- management. We trialled the use of IV FCM in patients whom it is indicated during the post-procedure observational time.

Methods Since January 2013, patients receiving IV FCM post endoscopy had their details recorded in a database.

Results - 15 patients underwent IV FCM infusion post endoscopy;

- 9 women / 6 men, age range 33–83, mean age 64/ median 70;
- Mean dose 940mg / median 935.7mg (12 patients received 1g IV);
- 13 patients received IV sedation during endoscopy;
- 6 had gastroscopy, 9 had colonoscopy;
- Indication (s): Intolerant to oral iron 8, severe IDA 9 (GAVE, CRC), malabsorption 1;
- Adverse events: 1 patient with bruising post IV cannula removal (not related to FCM).

Conclusion The safety and cost effectiveness of IV FCM has been established. This study shows that this is also the case for patients who receive IV FCM post endoscopy.

The benefits of this approach are significant. Patients are already observed post-endoscopy so giving a short IV infusion is appropriate and does not require extra staff. This is also very convenient for patients, reducing the number of attendances required in addition to the benefits of IV iron for anaemia. Giving IV FCM post endoscopy reduces the costs significantly when compared those of a separate appointment to a day case unit.

REFERENCE

- 1 Andrew F Goddard, Martin W James, Alistair S McIntyre, Brian B Scott, on behalf of the British Society of Gastroenterology. Guidelines for the Management of Iron Deficiency Anaemia. *Gut* 2011;60:1309–1316

Disclosure of Interest None Declared.

PTH-019 THE EFFECT OF THREE INTERVENTIONS ON COLONOSCOPY QUALITY OUTCOMES - AN EXEMPLAR FOR ENDOSCOPY UNITS

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Introduction Kettering General Hospital's endoscopy unit performs >1300 colonoscopies per annum (symptomatic, surveillance and bowel cancer screening).

During 2012, three interventions took place in the unit.

1. The vetting guidelines for requesting colonoscopy were updated to reflect BSG guidance for the management of iron deficiency anaemia and NICE guidelines for colorectal cancer. The aim was to reduce the number of inappropriate colonoscopies, especially in those patients not fit for colonoscopy.
2. The information leaflets sent to patients pre-colonoscopy had a prompt added to urge patients to take the full dose of 4 sachets of Klean Prep (polyethylene glycol) to improve the diagnostic quality and exclusion value.
3. Three colonoscopists who were not meeting key performance indicators stopped performing colonoscopy. This allowed the remaining operators to increase the number of colonoscopies they perform.

We have audited the effects of these interventions individually and overall.

Methods We compared data from 2013 to 2011 to assess the impact of the intervention undertaken.

1. To assess the impact of the change in vetting guidelines, we measured the number of patients with ASA grade 3 or 4 who underwent colonoscopy.
2. To assess the impact of the change in patient information, we measured the number of sachets of Klean prep taken by patients and the assessment of the quality of bowel preparation.
3. To assess the impact of certain operators stopping performing colonoscopy, we measured the number of operators (excluding trainees) who performed >100 colonoscopies per annum and those with caecal intubation rate (CIR) >90%.
4. To measure the combined effect of the interventions, we looked at the combined CIR of all operators within the department.

Results

Abstract PTH-019 Table 1

Measure	2011	2013	P value
Number	1563	1338	
Patients ASA grade 3 or 4	47 (3.01%)	33 (2.47%)	
Good/excellent bowel prep	1206 (77.16%)	192 (12.28%)	
Poor bowel prep	1060 (79.22%)	147 (10.99%)	
Mean dose of Klean prep	3.55	3.71	<0.0001
Operators >100 per annum	6 of 11	5 of 6	
Operators CIR >90%	7 of 11	4 of 6	
Overall CIR	90.21%	94.54%	<0.0001

Conclusion All three interventions have caused improvements in measured outcomes. Fewer patients with significant co-morbidities are undergoing colonoscopy. The bowel preparation has improved and there is a statistically significant increase in the mean dose of Klean prep taken. The changes in the number of operators undertaking colonoscopy have allowed fewer operators to do more procedures. Intuitively, practice makes perfect and this along with the other interventions has significantly improved the combined CIR of all operators from 90.21 to 94.54% ($p = <0.0001$).

The implementation of interventions outlined has been rewarding and is an exemplar to other endoscopy units on how to improve key quality outcomes of their colonoscopy practice.

Disclosure of Interest None Declared.

PTH-020 RETROSPECTIVE COHORT STUDY TO DETERMINE THE OPTIMUM FREQUENCY OF SURVEILLANCE COLONOSCOPY FOR PATIENTS WITH INTERMEDIATE GRADE COLORECTAL ADENOMAS IN THE UK

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Introduction Colonoscopic surveillance for colorectal cancer (CRC) is widely practiced; however, there remains a lack of evidence to determine appropriate surveillance intervals for individuals at intermediate risk (IR) of CRC. Due to the considerable strain on endoscopic resources and serious cost implications, it is vital to optimise surveillance strategies to ensure colonoscopy is

targeted at those who will benefit most. This study examines the frequency of surveillance in patients with intermediate grade (IG) adenomas, aiming to assess whether there is significant heterogeneity in the detection of advanced neoplasia within this group, according to baseline findings and surveillance interval length.

Methods A retrospective cohort design was used in a secondary care setting. 18 UK hospitals were selected based on the availability of electronic patient data suitable for automatic extraction. Endoscopy reports containing Systematised Nomenclature of Medicine codes or words relating to adenomas were identified and linked to corresponding pathology records. These were extracted from hospital databases before being pseudo-anonymised, formatted and uploaded onto an APEX database to be interpreted and coded. Patients were excluded from the analysis if they had no IG adenomas, no baseline colonoscopy, any missing exam dates or conditions affecting CRC risk. Baseline and follow-up visits, and polyp characteristics, were defined using a series of rules developed by the study team. Outcome measures used were advanced adenomas (AA) and CRC; information on these was obtained using follow-up data from external sources, in addition to the hospital data.

Analysis of risk of AA and CRC at each follow-up visit, according to baseline findings and interval length, will be performed through the use of descriptive statistics and logistic regression.

Approval was obtained from the National Research Ethics Service, Caldicott Guardians and the National Information Governance Board. As it was not feasible to seek patient consent, patient confidentiality was ensured through pseudo-anonymisation of data.

Results Endoscopy and pathology data from over 200,000 patients was collected and coded, and a large bespoke database was created to store this data. A total of 11,995 IR patients with a baseline colonoscopy were identified for analysis, 4,694 of whom have at least one follow-up visit.

Conclusion Analysis of the data is currently in progress. When completed, later this year, conclusions will be drawn on the optimal surveillance intervals for IR patients. The database will also act as a unique resource for further studies involving patients at both low and high risk, and for examining the association between serrated lesions and proximal CRC.

Disclosure of Interest None Declared.

PTH-021 NUTRITION ASSESSMENT IN THE ACUTE MEDICAL UNIT

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Introduction Malnutrition can increase hospital mortality rates, worsen clinical outcomes and increase the length of hospital stays. Those at particular risk include patients with cancer, gastrointestinal and neurological disease. We wanted to review whether patients admitted to the Acute Medical Unit were adequately assessed for malnutrition and whether identified patients had been referred to or received specialist nutritional assessment and support in a prompt manner.

Methods A prospective audit was performed on 77 acute medical admissions. Data was collected during the first 48 h of the patients' stay and was compared to the current recommendations highlighted in the NICE Clinical Guideline 32 – 'Nutrition