follow-up appointments generated or discharge rates from clinic. During the study period, nurse led care resulted in increased resource use compared with consultant led care – but could be partly explained by the greater proportion of patient seen in the 'suspected cancer' pathway. No adverse outcomes or missed diagnoses were observed over an 18 month follow up period. Our study would support the role of specialist nursing managing unselected patients in gastroenterology clinics.

Disclosure of Interest None Declared.

PTH-031 AN INCREASING DEMAND FOR ENHANCED SEDATION ENDOSCOPY: A SINGLE CENTRE EXPERIENCE

[1]D Joshi*, [1]M Austin, [2]T Bate, [1]S Cairns. *[1]Digestive Disease Centre, Brighton and Sussex University Hospital, Brighton, UK; [2]Department of Anaesthesia, Brighton and Sussex University Hospital, Brighton, UK*

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Introduction The demand for enhanced sedation endoscopy (ESE) appears to be increasing due to increasingly challenging diagnostic and therapeutic procedures. BSG Working Party guidance were issued in 2011.[1] Our aim is to describe a single centre experience and highlight the importance of providing such a service.

Methods Retrospective review of all patients undergoing elective ESE at Brighton and Sussex University Hospital (BSUH) from March 2012 to March 2013. Cases were performed in the endoscopy department and in a day surgery theatre. Patients were identified using the Unisoft endoscopy program and day theatre list records. Patient records were reviewed in addition to endoscopy reports. Data collection included patient demographics, indication for procedure, procedure length, success of procedure if previously failed and complications. Data presented as median with range.

Results A total of 89 procedures (OGD x 25 (28%), colonoscopy x 28 (31%), flexible sigmoidoscopy x 2 (2%), ERCP x 24 (27%), OGD/colonoscopy x 10 (9%)) in 79 patients were performed. Median age 53 years (22–75 years), weight 77.5kg (52–126 kg), BMI 26 (22–48), female 60%, ASA 2 (1–4). Indications for ESE included a previously poorly tolerated procedure (38%, n = 34), co-morbidities (24%, n = 21), patient choice (20%, n = 18), previously failed procedure (9%, n = 10) and likely long procedure (7%, n = 6). 80 patients received a combination of propofol/ fentanyl sedation whilst 9 patients required a full general anaesthetic. ESE was delivered by a designated anaesthetist. Median duration of procedure was 35 min (10–65 min). There were no endoscopic related complications. 1 patient developed hypotension requiring intravenous fluids and was admitted for observations overnight and 1 patient developed bronchospasm post extubation requiring intravenous steroid and nebulisers but did not require admission. The use of ESE resulted in the successful completion of all endoscopic procedures.

Conclusion Review of our referrals demonstrates an increasing demand of ESE. Our service initially began as an ad hoc list but now is weekly. ESE appears to be a safe, time efficient and reduces the requirement for repeat procedures.

REFERENCE

1 Guidance for th, UKe use of propofol sedation for adult patients undergoing ERCP and other complex upper GI endoscopy procedures, April 2011. RCoA and BSG working party

Disclosure of Interest None Declared.

PTH-032 GUT HORMONE SCREENING FOR GASTROENTEROPANCREATIC NEUROENDOCRINE TUMOURS – A QUALITY IMPROVEMENT PROJECT

[1]D Mansour*, [2]T Lee. *[1]Gastroenterology, Gateshead Queen Elizabeth Hospital, Newcastle Upon Tyne, UK; [2]Gastroenterology, Northumbria Healthcare Trust, North Tyneside, UK*

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Introduction BSG guidelines advise that, in patients presenting with symptoms suspicious of gastroenteropancreactic neuroendocrine tumour (NET), baseline gut hormone (GH) tests should include Chromogranin A (CgA) and urinary 5HIAA. Other specific biochemistry should be requested depending on the syndrome suspected. We reviewed the use of gut hormone screening in a North East England Trust and examined the association between positive results and NET diagnosis.

Methods We reviewed all GH screens requested between July 2012 and June 2013. The following data were collected: specialty of requesting physician, indication, results and clinical outcome. We compared results of GH screens (CgA and then other GHs) with the diagnosis of NET to calculate specificity. Finally, we looked at all NET diagnosed in the trust over the same period, reviewing GH levels in those tested following diagnosis, in order to calculate sensitivity. Financial implications of different GH testing strategies were assessed using these results.

Results Of a total 51 requests for gut hormone screens, 21 were made by gastroenterologists and 8 by surgeons. 19 requests in total were made for investigation of diarrhoea, 12 for upper GI symptoms/peptic ulcers, 5 following positive histology or lesions on imaging and 15 for other symptoms. A total of 459 GH were tested at a cost of £315 per patient. 32/51 patients had normal CgA levels, none of which went on to be diagnosed with NET. 19 had a raised CgA of which 2 were already known to have NET but no new NET were found (specificity 65.31%). Patients with diarrhoea had a particularly high false positive rate (7/19=37%). Of 18 patients newly diagnosed with NETs in the trust, 5 had GHs tested (all following diagnosis)-3/5 had raised CgA (cost £44 per patient),a sensitivity of 60% (this increased to 80% when combined with u5HIAA testing). Measuring other gut hormones only marginally increased sensitivity but greatly reduced specificity of the screening.

Conclusion Gut hormone screening was not being performed in line with BSG recommendations in our Trust, leading to excessive numbers of tests being performed with low sensitivity and specificity. We worked with the trust biochemistry department to clarify the indications for GH testing and rationalise the screening test performed. We now offer an 'endocrine diarrhoea screen' of CgA and u5HIAA. Other hormones are measured only if a specific syndrome is suspected/in patients with known history/family history of NET, representing a cost saving of £271 per patient. It is envisaged that this change in practice will save the trust at least £12,000 per annum whilst improving clinicians` decision making around testing for NET.

Disclosure of Interest None Declared.

PTH-033 A SPECIALIST IRON DEFICIENCY ANAEMIA CLINIC SIGNIFICANTLY REDUCES THE NEED FOR SECONDARY CARE FOLLOW UP

E Taylor*, J Campbell, M Donnelly, J Hebden. *Gastroenterology, Sheffield Teaching Hospitals, Sheffield, UK*

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