

the planned surveillance date, either due to inadequate biopsies being taken to delay/discharge or appropriate date of surveillance already booked. 15/125 (12%) patients were either discharged or had their OGD delayed. If all procedures had been compliant with BSG standards this might have led to more than three times as many patients having their surveillance discontinued or delayed (48/125:38%).

Conclusion Using the 2013 BSG guidelines enables departments to safely discharge patients with Barrett's oesophagus or increase surveillance intervals. This will save money and reduce the risk and discomfort inherent with this program. Endoscopists adherence to the Seattle biopsy protocol is poor, and this is the main barrier preventing more patients from being discharged.

REFERENCES

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Disclosure of Interest None Declared.

PTH-038 ALBUMIN AS A PLASMA EXPANDER DURING LARGE VOLUME PARACENTESIS: ARE WE FOLLOWING THE GUIDELINES?

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Introduction Ascites is a major complication of cirrhosis occurring in more than 50% of patients within 10 years. Tense ascites is treated with large volume paracentesis (LVP) with human albumin solution (HAS) as a plasma expander. National and International guidelines recommend that cirrhotic patients undergoing LVP (>5 l) should have 8 g of HAS per litre of ascites drained. This equates to 1 unit of 20% HAS per 2.5 l of ascites drained. HAS is not recommended for non-cirrhotic ascites or small volume paracentesis (SVP), where <5 l of ascites is drained. Our aim was to see if local practice followed guidelines.

Methods We conducted an audit of all paracenteses occurring in a London district general hospital between January 2012 and October 2013. We included day unit patients and inpatients undergoing paracentesis. We reviewed medical notes, prescription charts and nursing records, including cases with suitable documentation.

Results Sixteen patients had a total of 48 drainage episodes between them, of which 9 were male and median age was 71 years (range 45–93 years). Eleven patients had cirrhosis and 5 had non-hepatic malignancy. Table 1 demonstrates that there were 36 paracentesis episodes in cirrhotic patients where LVP was carried out with a median of 4 units of HAS given per drainage. On the other 12 occasions HAS did not need to be

given. In 20/36 cases at least 2.5 l of ascites was drained for each unit of HAS given. In the 16 other cases of LVP in the cirrhotic patients, HAS was overprescribed with a total of 19 units being given unnecessarily in this group.

In total 25 units of HAS were given to patients undergoing small-volume paracentesis and those with malignant ascites. The cost per unit of HAS is £29, thus potentially £1276 could have been saved if guidelines had been followed. There were no complications associated with drain insertion nor was there any hypotension, acute kidney injury, or electrolyte disturbance related to HAS infusion.

Conclusion Albumin is often inappropriately prescribed to patients with malignant ascites and those undergoing small volume paracentesis. Of the paracenteses where HAS was indicated, 16/36 (44%) were overprescribed albumin. This has unnecessary cost implications as well as potential health risks due to the hyperoncotic properties of HAS. We conclude that reducing HAS usage by following guidelines during LVP would reduce costs without compromising patient safety.

REFERENCE

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Disclosure of Interest None Declared.

PTH-039 PREVENTING POST-ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP) PANCREATITIS: CHANGING PRACTICE AT A DISTRICT GENERAL HOSPITAL

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Introduction Post-ERCP pancreatitis (PEP) is one of the major endoscopic complications carrying 3.5% risk in unselected patients. Daycase ERCP is now the norm in the UK and emergency presentations with PEP may be expected. At Basildon Hospital, we sought to adopt ESGE guidelines (2010)¹ to prevent PEP with regards to: serum amylase testing, rectal non-steroidal anti-inflammatory (NSAID) and pancreatic duct (PD) stent use. Since March 2013, a protocol incorporating these recommendations was followed.

Methods A prospective audit between December 2012 to 2013 was performed to evaluate the effect of this management protocol. Data was collected on an audit proforma completed immediately following ERCP. Patient outcome was followed up via telephone on subsequent day or review of inpatient notes. Electronic records were searched for admissions within 2 weeks of ERCP.

Results 249 ERCP procedures were recorded over the 12 month period. 41% were male; 45% were performed as outpatient. Mean age was 68 years. Main indication was gallstones (60%).

Abstract PTH-038 Table 1

Cause of Ascites	Type of drainage	Number of drains	Median amount (Range) of ascites drained (L)	Median amount (Range) of HAS given (units)
Cirrhosis	LVP	36	9.9 (5.5–16.5)	4 (3–9)
	SVP	4	2.4 (1.2–4.45)	1.5 (1–3)
Malignant ascites	LVP	5	7.2 (5.0–8.0)	3 (3–5)
	SVP	3	3.8 (1.5–4.4)	0