

were abnormal liver tests [predominantly transaminitis] (n = 11); myelosuppression (n = 6). Six patients were admitted to hospital [myelosuppression n = 2, pancreatitis n = 1, unrelated to IMD n = 3]. Management of adverse events included changing to an alternative agent (n = 13), dose adjustment (n = 12) and discontinuation of IMD (n = 10).

Conclusion A pharmacist-led clinic is a safe alternative to conventional gastroenterology clinics for monitoring of patients on IMD. Adverse events were picked up early and adequately acted upon. There was a high level of patient compliance and reduced number of clinic visits; the average numbers of clinic visits saved were 10 per patient.

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Disclosure of Interest None Declared.

PTH-044 A SINGLE-CENTRE PILOT STUDY EXAMINING INTERNET USE FOR HEALTH RELATED INFORMATION AMONG PATIENTS WITH INFLAMMATORY BOWEL DISEASE

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Introduction The internet offers a wealth of information for patients with chronic disease, facilitating education and shared decision making; however, this can often be unregulated and inaccurate.¹ Inflammatory bowel disease (IBD) patients use of the internet has been investigated² but no studies have examined whether internet use alters with disease activity or influences patients decisions regarding health. We evaluated patients internet use for health-related information (HRI), including factors influencing website choice and whether this information influences decisions regarding healthcare or changes with disease severity.

Methods A prospective, pilot survey of 170 consecutive patients attending the IBD clinic over a one month period in November 2013. The anonymous questionnaire included demographic information on age, gender, education level, diagnosis and disease activity. There were also questions regarding use of the internet for HRI, determinants of website quality and influences of information found on the internet on decisions affecting their health.

Results A total of 136 IBD patients completed the questionnaire (80% response rate), 60 [44%] male, age 18–85 years [median age 37 years] 67 [49%] had CD; 84 [62%] reported a flare of symptoms in the preceding 6 months. 126 (93%) use the internet, 110 (81%) of which access HRI information via the internet. 94% of patients were educated to completion of high school or above and level of education did not affect internet use. Using NHS direct (46%), Crohn's and colitis UK (40%) and IBD forums (29%), patients searched for general health (77; 57%); IBD specific (63; 46%) and medication (47; 35%) information. 45 (33%) stated that information found on the internet would influence their choice of medication, irrespective of a flare within the last 6 months. 71% (96) felt confident that they could obtain factual information on the internet, although when determining website quality, overall appearance and position in search engines and whether the site was non-commercial were ranked least important and IBD-specific sites from a reputable source most important.

Conclusion In our study, internet use is shown to be a major source of disease –specific information and can affect patients'

decision making. Internet usage and type of information sought do not alter with disease activity, suggesting that information is equally useful to all patients with IBD.

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PTH-045 INTEGRATED ALCOHOL AND HEPATOLOGY MDT: REDUCING ALCOHOL-RELATED HOSPITAL ADMISSION AND ATTENDANCE

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Introduction In 2010 a joint position paper on behalf of British Society of Gastroenterology, the Alcohol Health Alliance UK, and the British Association for Study of the Liver highlighted that the most deprived lifestyle groups have up-to 15 times greater alcohol-specific mortality and up to 10 times greater alcohol-specific admissions to hospital. It therefore recommended that each acute hospital should develop a multidisciplinary approach to the care and management of people attending or admitted to hospital with an alcohol-related cause.¹

Methods We conducted a notes review of all patients attending or admitted to the hospital on more than 6 occasions in the previous 6 months. We also compiled 3 in-depth case studies of our most frequent attenders. We investigated the reason for admission including medical and social confounders. We then looked at the range and number of medical and social disciplines involved in their care, discharge planning and aftercare. We spoke to our patients about why they had chosen to attend hospital and what they felt could be provided as an alternative. We developed an electronic early warning system to inform the Alcohol Team when a patient was admitted. This triggered referral to our integrated alcohol and hepatology consultant led MDT

Results Our investigations showed that the majority of patients had a range of support including key workers from a variety of voluntary agencies, housing agencies, GP's, primary care alcohol specialist nurses, social workers, homeless outreach, and specialist medical consultants from psychiatry to hepatology. However, much of this work was happening in isolation and was at times conflicting with no one organisation or professionals supporting or mapping out the patients journey. Importantly, the patients were unclear where to go for what, and were often utilising the ED as a failsafe when they were unsure or troubled. The MDT is a vehicle to ensure that the patient gets the right treatment at the right time by the right person; which has helped our patients better understand their care pathways and their aims. This has resulted in a significant reduction in hospital attendance and admission for this small but significant patient group.

Conclusion An MDT for alcohol-related admissions augments and centralises the expertise of health and social care partners in the development of truly patient centred shared plans of care. This leads to hospital admission only when appropriate and necessary

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Disclosure of Interest None Declared.