

Abstract PTH-128 Table 1 Anatomical and histological distribution of SBC

	Duodenum	Jejunum	Ileum	Unknown	Total
Adenocarcinoma	21	9	4	3	37
Neuroendocrine	3	1	6	1	11
Sarcoma	1	0	0	1	2
Unknown	75	12	20	48	155
Total (n)	100	22	30	53	205

retrospectively reviewed medical records collecting data on patient demographics, environmental and medical risk factors, family history, natural disease progression and immunohistochemical analysis (IHC).

Results The registry identified 205 SBC patients, 58% male and 42% female, who were diagnosed at a mean age of 63 years. Patients presented with abdominal pain (23.3%, n = 60), altered bowel habit (16.7%), weight loss (15.0%), bowel obstruction (15.0%) jaundice (13.3%), anaemia (10.0%) and other (6.6%). Investigations included CT (85.7%, n = 35), MR (8.6%) and barium (11.4%) imaging; gastroscopy (37.1%) that detected 8 of 9 duodenal SBCs and were reported normal in 2 jejunal and 2 ileal SBCs, DBE (2.9%) and ERCP (2.9%) that detected 1 duodenal SBC each; emergency (8.6%) and staging laparotomy (8.6%). SBC anatomical and histological distributions are described in Table 1. Patients were diagnosed at disease stage I (11.4%, n = 35), II (22.9%), III (20.0%) and IV (45.7%). Treatment included curative surgery (66%, n = 38; 12 resections, 7 bypasses and 6 Whipple procedures and adjuvant chemotherapy (AC) in 20%) with a 60% success rate and recurrence in 16.7% within a year; palliative surgery (18.4%; 6 bypasses and AC in 66.7%) and medical palliation (15.6%). Mortality rates at 1, 2, 5 and 10 years were 74.3%, 79.8%, 91.7% and 98.2% respectively (n = 109). Environmental factors included smoking (47%, n = 53) and drinking alcohol (51.1%, n = 45). Co-morbidities included peptic ulcer disease (8.4%, n = 72), coeliac disease (4.2%), Crohn's disease (1.4%) and ulcerative colitis (1.4%). Furthermore, 23.6% of patients (n = 89) had ≥ 1 other malignancies that were metachronous (83.3%), synchronous (12.5%) or both (4.2%). Family history included a 1st or 2nd degree relative with malignancy (28.2%, n = 39) or familial adenomatous polyposis (7.7%). IHC showed Lynch syndrome and adenomatous polyposis coli gene mutations in 42.1% (n = 19) and 40% (n = 10) respectively.

Conclusion Our understanding of SBC is limited by its insidious course, difficult assessment and rarity coupled with multiple histological subtypes. A more comprehensive understanding of SBC and its genetic predisposition may allow high-risk patient stratification to earlier identify and treat SBC thus improving its poor prognosis.

REFERENCE

- 1 Ross et al. *British Journal of Cancer* 1991;63:143–145

Disclosure of Interest None Declared.

PTH-129 A RETROSPECTIVE AUDIT OF PEG INDICATIONS AND COMPLICATIONS AT A DISTRICT GENERAL HOSPITAL FOLLOWING THE INTRODUCTION OF A MULTI-DISCIPLINARY NUTRITION TEAM

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Introduction Percutaneous endoscopic gastrostomy (PEG) is the preferred method for inserting feeding gastrostomy tubes. The national confidential enquiry into PEG outcomes showed that patient selection was paramount for improving associated mortality and morbidity rates [1]. We carried out a retrospective audit into the indications and complications associated with PEG insertion at West Suffolk Hospital, a district general hospital, during 2008–2009 and 2013. During this period a multidisciplinary nutrition team approach and PEG referral proforma were introduced.

Methods Retrospective audit data were collected during two periods, January 2008 to December 2009 and January to September 2013. The indication for PEG, documentation of antibiotic prophylaxis, the presence of a MDT review and complications post PEG insertion were audited.

Results 55 PEG placements occurred during the first audit cycle. 56% were inserted for dysphagia caused by cerebrovascular accident. Antibiotic prophylaxis were documented in 80% of cases. Seven patients did not have an MDT discussion during the admission. There were no immediate complications. Three patients died within 30 days of PEG insertion (two died of pneumonia and one from large bowel obstruction). There were 36 PEG insertions during the second audit cycle. 39% were inserted for dysphagia caused by CVA. Antibiotic prophylaxis were documented in 83% of cases. All patients had an MDT discussion. Two immediate complications were reported. There were no reported deaths 30 days post procedure.

Conclusion Following the introduction of a systematic MDT approach to PEG, there has been a reduction in 30 day mortality post-PEG insertion. When carefully monitored the use of PEG for long term enteral feeding can be used safely and successfully in a district general hospital.

REFERENCE

- 1 Simon D, Johnston Tony CK, Tham Marisa Mason, Death after PEG: results of the National Confidential Enquiry into Patient Outcome and Death. *Gastrointestinal Endoscopy* August 2008; 68(2):Pages 223–227, ISSN 0016–5107

Disclosure of Interest None Declared.

PTH-130 A COMPARISON OF THE NUTRITION SCREENING TOOL AND MALNUTRITION UNIVERSAL SCREENING TOOL ON REFERRAL RATES FOR DIETETIC ASSESSMENTS

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Introduction We aimed to compare the “Nutrition Screening Tool” (NST) and the “Malnutrition Universal Screening Tool” (MUST) on referral rates for dietetic assessments in in-patients in a Tertiary Neurology and Neurosurgery unit. Each tool generates a score above which dietetic assessment is recommended (a NST a score of 12 or more out of 22, a MUST score of 2 or more out of 5). The MUST score is considered the gold standard assessment method. The NST has been introduced in some centres with anecdotal reports of a reduction in referrals for dietetic assessment.

Methods In-patients at the National Hospital for Neurology and Neurosurgery were assessed for a one month period. The NST and MUST was completed on all available in-patients. A comparison of the number of referrals to dieticians was made using each assessment tool.

Results 136 patients were screened. There were 77 women and 59 men. The age range was 18–89 years. The mean age was 52.4 years. For women the mean age was 49.7 years. For men the mean age was 56.0 years.

There was a highly significant difference in the numbers referred to the dietitians. Using the NST scores, 3 out of 136 patients scored 12 or more (3 referrals (2%)). Using the MUST scores, 20 out of 136 patients scored 2 or more (20 referrals, (15%)) ($P < 0.0001$).

The NST identified that 12 patients scored 8 or more. 7 of these had a MUST score of 2 or more. This means 58% of patients who score 8 or more using the NST would have been referred using the MUST. The NST identified that 13 patients scored 7 or more. 8 of these had a MUST score of 2 or more. This means 62% of patients who score 7 or more using the NST would have been referred using the MUST.

The NST identified that 14 patients scored 6 or more. 9 of these had a MUST score of 2 or more. This means 64% of patients who score 6 or more using the NST would have been referred using the MUST.

Conclusion Using the NST results in a significantly lower number of referrals to dietitians compared to when nutritional assessment is made using the MUST score. This may be due to the NST score required for referral being too high. Therefore the NST needs to be revalidated using a lower referral score, possibly between 6 and 8. Further studies are required in order to ascertain the specific NST score appropriate for referral.

Disclosure of Interest None Declared.

PTH-131 ENDOSCOPIC GASTROPEXY AND PEG FEEDING TUBE INSERTION: A COMPARATIVE STUDY

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Introduction PEG feeding in patients with head and neck and upper GI cancers is known to derive nutritional and mortality benefits. Standard inside-out PEG insertion is not always technically possible or safe especially when there is narrowing of the oesophagus or pharynx from cancer. There is also concern about tumour seeding with inside-out technique. Similarly, in some patients it is not possible to pass the standard gastroscope through to upper GI tract. Gastropexy is an alternative technique which allows insertion of a gastrostomy tube with outside-in technique and can be performed using ultrathin scopes rather than standard gastroscopes. Gastropexy has been routinely performed in our unit for some time. We aimed to review the experience of Gastropexy insertion in our unit and compare it to age and indication matched controls who underwent PEG insertions.

Methods A retrospective review of institutionally approved PEG database was conducted. Gastropexy insertions between June 2009 and November 2012 and PEG insertions between March 2006 and January 2012 were reviewed retrospectively. Indication and age matched PEGs were used as controls. Patients with cancers (head and neck, oesophageal and other) undergoing the procedure were selected. Patient characteristics, sedation requirement, technical success, success using ultrathin scopes, safety, complications if any and mortality rates were recorded.

Results Fifty four patients received 57 gastropexies (30 males, median age 63 (range 39–84) years); 108 patients received 109 PEG's (55 males, median age 68 (range 20–93) years).

Abstract PTH-131 Table 1

	Gastropexy	PEG	P value
Mean age (years)	63.2	66.9	0.08
Mean Midazolam (mg)	3.3	3.7	0.1
Mean Pethidine (mg)	25	0	<0.001
7-day mortality (%)	3.5	6.4	0.43
28-day mortality (%)	14	18.3	0.48
Indications	%	%	-
Head and neck cancers	68	67	-
Oesophageal cancers	21	6.4	-
Cancers elsewhere/extrinsic compression	2	26.6	-

Eighty three percent of gastropexy and 97% of PEG's were done under conscious sedation. The remaining gastropexy insertions were done under GA as a part of another surgical procedure. Technical success was achieved in 98 and 100% for gastropexy and PEG's respectively. Minor gastric fluid leak in 1 patient in gastropexy group and mouth bleed in 1 patient in PEG group was noted. No procedure related deaths were noted in either of the groups.

Conclusion In the context of risk from tumour seeding and mucosal trauma to narrowed upper GI tract, endoscopic gastropexy procedure seems non-inferior to PEG's. It seems safe and can be done with high technical success rate. Perhaps, it may be an alternative to PEG in patients with inherently difficult upper GI tract and major illness like cancers.

Disclosure of Interest None Declared.

PTH-132 GASTROSTOMY INSERTIONS: IS IT ALL ABOUT CHOOSING THE RIGHT PATIENTS? A COMPARISON BETWEEN PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) AND RADIOLOGICALLY INSERTED GASTROSTOMY (RIG) INDICATIONS, COMPLICATIONS AND MORTALITY RATES

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Introduction Nottingham University Hospitals (NUH) NHS Trust serves as a tertiary centre for Gastroenterology, Stroke, Neurosurgery and Oncology. Our current practice for vetting referrals differs for PEG and RIG. PEG requests are forwarded to the Nutrition Team for vetting. RIG referrals are sent directly to Radiology for vetting. Our Specialist Nutrition nurses provide a robust assessment including clinical assessment, dietician and speech and language therapy review. Complex cases are discussed with a Gastroenterologist. Pre-procedure review of RIG patients may be undertaken by any physician.

Methods We retrospectively reviewed all PEG and RIG referrals from 2012. The nutrition records, case notes and electronic records were reviewed. We collected data on referring specialty, indication and 30-day complication and mortality rates. Data was collated onto a database for analysis.

Results 329 referrals were received; 148 for PEG and 181 for RIG. Of these, 76 (51.4%) were deemed appropriate for PEG and 168 (92.8%) for RIG. Reasons for refusal included patient fitness, meeting nutritional needs, suitable for alternative method of feeding or unsuitable for anatomical/technical reasons. Main service users were Stroke and Neurology, other medical specialties, Clinical Oncology, Neurosurgery and Ear, Nose and Throat.