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 dieticians. 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.