

clinic assessment first. Mean wait on pathway for 2WW 12.4 days (range 4–20), and for 18WW 28.8 days (range 15–42), all breaches by patient choice. This represented a reduction from the normal pathway of 48% (2WW) and 67% (18WW). DNA rate was low at 1% (unit average 7%). Most common diagnoses were polyps (20%), diverticular disease (20%), IBD (9%). 1 patient had colorectal cancer – a further patient was diagnosed with pancreatic cancer on CT pneumocolon following a failed colonoscopy. 13% patients required clinic follow up. An estimated saving of £14156 was made from out-patient clinic slots that were no longer necessary, with cancellation of over seven new out-patient lists.

**Conclusion** These data suggest that the introduction of a novel pathway for patients with LGI symptoms can produce significant benefits to the patient in terms of time to definitive endoscopic diagnosis. A financial benefit is also clear, as is the opportunity to redeploy clinic doctors elsewhere.

#### REFERENCE

Wright HL. *Colorectal Dis* 2012;14:10

**Disclosure of Interest** None Declared.

#### OC-057 IN. OUT. "NEXT PLEASE!" CAN PERSON-CENTRED CARE BE DELIVERED IN ENDOSCOPY?

L Ferris\*, S Henderson. *Endoscopy Unit, Belfast City Hospital, Belfast, UK*

10.1136/gutjnl-2014-307263.57

**Introduction** In. Out. "Next please!" Is this the image of endoscopy nursing? It can often be difficult to personalise care or care delivery with such a rapid turnover of patients. As registrants we have a duty to deliver safe, effective, person-centred practice (PCP). Staff at the Belfast City Hospital opted to explore this concept further.

**Methods** In order to understand the nature of PCP we used emancipatory practice development tools, as this is the only service improvement methodology which has the delivery of PCP as the explicit outcome. To increase awareness of "self," staff initially were invited to explore their own inherent values and beliefs, facilitated through a Values Clarification Exercise (VCE) using critical creativity [1]. The VCE helped identify key themes which formed the basis of our visioning statement. We used the *15 Steps Challenge*[2] and Workplace Critical Culture Analysis Tool (WCCAT)[3] to explore the prevailing culture within the department and establish if we were indeed person-centred.

**Results** Integral to the PCP framework [1] is the therapeutic relationship between service users and care providers. Working on the premise that "first impressions count," the *15 Steps Challenge* was performed by key stakeholders and facilitated by junior nursing staff. Observations were made in four key areas of practice. Feedback was collated and presented to the ward manager and a subsequent action plan created, which included improvements to the reception area. In addition, to further explore the workplace culture, eight observations of practice were undertaken using the WCCAT by a representative staff group. These findings were then presented to the wider team who prioritised areas for action.

**Conclusion** We believe PCP should not be viewed as a one-time event, but rather a continual process embedded in everyday practice. We are confident that this premise can be extrapolated to any endoscopy unit where staff are empowered to deliver person-centred care. It is our intention to repeat the *15 Steps*

*Challenge* and WCCAT in late 2014 to demonstrate the continual process of improvement of increasing effectiveness. <sup>1</sup>

#### REFERENCES

- McCormack B, Titchen A. Critical creativity: melding, exploding, blending. *Educational Action Research: an International Journal*. 2006;14(2):239–266
- National Health Service Institute for Innovation and Improvement. *Putting Patients First – The Productive Series*. Coventry: NHS Institute for Innovation and Improvement. 2012
- McCormack B, Henderson E, Wilson V, Wright J. Making practice visible: the workplace culture critical analysis tool (WCCAT). *Practice Development in Health Care* 2009;8(1):28–43
- McCormack B, McCance, T. *Person-Centred Nursing Theory and Practice*. Sussex, Wiley-Blackwell. 2010
- Garbett R, McCormack B. A concept analysis of practice development. *NT Research*. 2002;7(2):87-100

**Disclosure of Interest** None Declared.

#### OC-058 AMBULATORY CARE ALCOHOL DETOXIFICATION (ACAD) AT WHITTINGTON HEALTH: A NEW APPROACH !

VSS Wong, R Turner\*, J Fleming. *Whittington Health, London, UK*

10.1136/gutjnl-2014-307263.58

**Introduction** Alcohol-related harm costs NHS £3.5 billion a year. It has become a "top priority" for the NHS. Alcohol Concern reported 1.2 million alcohol-related admissions in 2011/12, an increase of 135% over the last 10 years, but more people are also seeking and completing treatment. Current standard treatment for those actively withdrawing from alcohol is for inpatient (IP) detoxification and concurrent assessment and intervention by an Alcohol Liaison Nurse (ALN) which usually takes, on average, 5–7 days as an IP.

**Methods** A care pathway was formulated for inpatients to be referred to the AC service based on strict guideline. The AC centre dedicated 2 appointments daily within working hours (Mon-Fri) for outpatient (OP) detoxification. During each session, the ALN assessed, breathalysed the patient and completed a Clinical Institute Withdrawal Scale (CIWA). The AC doctor then prescribed a daily regimen of chlordiazepoxide on a symptom-dose basis. A retrospective audit was completed of all patients referred through this pathway.

**Results** From Jan 13-Dec 13, 19 patients (after medically assessed) were referred for the ACAD after 3 days. 14 patients engaged with the service and completed their AD. 10 male, 4 female, aged 28–68 years. All patients were admitted via Emergency Dept; 8 presented with alcohol withdrawal, 6 with other acute problems but concurrently treated for alcohol withdrawal whilst IP. 10 had physical co-morbidities; 2 had psychiatric co-morbidities. 6 patients had a previous history of seizures. 2/14 patients consumed alcohol during the AD phase of their treatment (noted on breathalysing the patients). These patients were subsequently discharged from ambulatory care and referred to local alcohol services. 1 patient required readmission to hospital for physical concerns relating to diabetes, completing the remainder of the detoxification as an IP. All patients agreed to be followed up in the community and have engaged with community services. The average duration of AD was 5 days. In previous study we have estimated that a 7 day inpatient admission as costing £2183 vs a 3 day admission with 3 follow up ambulatory appointments costing £1352. The potential cost saving is significant once this service is widely used.

**Conclusion** This small innovative pilot study demonstrates that ACAD can be an effective and safe approach to the managing

acute alcohol withdrawal; enable continued monitoring of vulnerable patients in a controlled OP environment. There is a need for a paradigm shift of offering AD in AC setting rather than IP treatment. Further patients are being recruited into an ongoing study.

#### REFERENCES

Public Health England, Alcohol Treatment in England 2012-13 Alcohol Concern, [www.alcoholconcern.org](http://www.alcoholconcern.org)  
Barry *et al.*, Alcohol Inpatient Detox: Withdrawing the burden of inpatient management. Gut, 2013

**Disclosure of Interest** None Declared.

#### OC-059 LOW DOSE AZATHIOPRINE AND ALLOPURINOL IN AZATHIOPRINE INTOLERANT PATIENTS: IS IT TOLERATED AND IS IT EFFECTIVE IN IBD?

HE Johnson\*, SA Weaver, SD McLaughlin. *Gastroenterology, Royal Bournemouth Hospital, Bournemouth, UK*

10.1136/gutjnl-2014-307263.59

**Introduction** Despite the advancement and introduction of new biological therapies, thiopurines remain effective treatment options for the maintenance of remission for both ulcerative colitis (UC) and Crohn's disease (CD). Once tolerated and therapeutic, thiopurines have many advantages over biologics for long-term maintenance therapy. However, it has been documented that intolerance and adverse events are common. We have previously published our 36 month follow-up data reporting that 56.5% of our patients stop thiopurines due to side effects, abnormal liver function tests (LFTs) or therapeutic failure.

Low dose azathioprine and allopurinol (LDAA) co-therapy is a well proven treatment option for patients who develop side effects or hepatotoxicity with standard dose azathioprine. LDAA has been used at our institution since 2010.

**Aim** to report the safety, tolerability and therapeutic outcome at 12 months, for LDAA in patients who have failed standard dose azathioprine.

**Methods** We maintain a prospective IBD data-base. After starting LDAA we monitor full blood count and LFTs weekly for 8 weeks. 6-Thioguanine (6-TGN) and 6-Methyl-mercaptopurine (6-MMPN) nucleotide levels are checked at 4-6 weeks. We searched our database for patients who started LDAA and had a minimum of 12 months follow-up. We recorded the indications for therapy, metabolite levels, and blood monitoring and clinical outcomes.

**Results** 62 patients were started on LDAA. 25 (40%) were male. Mean age was 47 (range 16 - 77). Disease type was UC, 21; CD, 35; IBD(U), 6. Reasons intolerant to standard dose azathioprine were: drug side effects (nausea and arthralgia) 24; hepatitis (ALT 2x upper limit normal) 20; Hypermethylation (TGN: MMPN ratio >11), 12. Gout 4; High TPMT 2.

At 12 months 44 (70%) remained on LDAA and were in clinical remission (HBI <1 for CD), (stool frequency <4 and no bleeding for UC) with therapeutic 6TGN levels on LDAA, of these 7 (11%) required additional treatment with biologic therapy.

Of the remaining 18 (29%) patients, 3 (5%) were lost to follow up and 1 (2%) chose to stop LDAA. 1 patient (UC) required a colectomy. 3 (5%) stopped LDAA to conceive.

10/62 (16%) remained intolerant and treatment was stopped.

One patient developed myelosuppression WCC <3 and stopped therapy. No patients developed abnormal LFTs on LDAA.

**Conclusion** LDAA is well tolerated and effective in patients who failed standard dose azathioprine due to drug side effects and hepatotoxicity. This therapy results in resolution of hepatotoxicity and will allow more IBD patients to achieve clinical remission.

**Disclosure of Interest** None Declared.

## Endoscopy section research symposium

#### OC-060 PERFORMANCE CHARACTERISTICS OF UNSEDATED ULTRATHIN VIDEO ENDOSCOPY IN THE ASSESSMENT OF THE UPPER GASTROINTESTINAL (GI) TRACT: SYSTEMATIC REVIEW AND META-ANALYSIS

<sup>1</sup>SS Sami\*, <sup>2</sup>V Subramanian, <sup>1</sup>J Ortiz-Fernández-Sordo, <sup>1</sup>A-H Saeed, <sup>3</sup>S Singh, <sup>3</sup>PG Iyer, <sup>1</sup>K Raganath. <sup>1</sup>Digestive Diseases Centre and NIHR Biomedical Research Unit, University of Nottingham, Nottingham, UK; <sup>2</sup>Institute of Biomedical and Clinical Sciences, University of Leeds, Leeds, UK; <sup>3</sup>Gastroenterology and Hepatology, Mayo Clinic, Rochester, MN, USA

10.1136/gutjnl-2014-307263.60

**Introduction** Unsedated ultrathin endoscopy has been proposed as a cost-effective and accurate alternative to standard endoscopy (SE) in screening for oesophageal varices, Barrett's oesophagus and upper GI neoplasia. However, reports on performance of this technique (both via the transnasal [TNE] and transoral [TOE] routes) are conflicting. We aimed to estimate the technical success rate, tolerability, acceptability and patients' preference for TNE and TOE alone and in comparison to SE.

**Methods** A systematic review and meta-analysis was performed of all primary studies reporting the outcomes of interest. Electronic databases (Cochrane library, MEDLINE, EMBASE) were searched from 1980 to September 1<sup>st</sup> 2013. Articles not published in English language were excluded.

Detailed data on study characteristics and endoscopic procedures was extracted. Study quality was assessed using the Cochrane Collaboration's tool for assessing risk of bias. Sources of heterogeneity were investigated using meta-regression and subgroup analysis.

**Results** 34 studies met the inclusion criteria with 6,659 patients in total. The pooled proportion of technical success rate was slightly lower for TNE (0.94; 95% confidence interval [CI]: 0.92, 0.96; 30 studies) compared to TOE (0.98; 95% CI: 0.96, 0.99; 16 studies). The difference in proportion of success for TNE compared to SE was -0.03 (95% CI: -0.13, -0.48; 18 studies), however, there was no significant difference in success rate between TNE <6 mm in diameter and SE (-0.14; 95% CI: -0.32, 0.05; 9 studies). Similarly, There was no significant difference between TOE and SE (0.03; 95% CI: -0.12, 0.17; 10 studies).

The standardised difference in mean tolerability scores was not significant for both TNE vs. SE (0.036; 95% CI: -0.435, 0.508; 11 studies) and TOE vs. SE (0.004; 95% CI: -0.417, 0.424; 7 studies). Proportion of patients willing to undergo the procedure again in future (acceptability) was high for both TNE and TOE (0.85; 95% CI: 0.79, 0.90; 16 studies and 0.89; 95% CI: 0.82, 0.93; 10 studies, respectively). The pooled difference in proportion of patients who preferred TNE over SE was 0.63 (95% CI: