Methods A retrospective cohort study (database and clinical note review) to compare numbers of children within the population of 838 573 in Lothian discharged on HETF from the single SE Scottish regional neonatal unit and the single SE Scottish regional paediatric unit, and their inter-relationships. All children and neonates discharged on HETF over the study period 1 July 2000–30 June 2011 were included. The fate of neonatal transfers requiring ETF to the paediatric centre was studied over the period of 1 July 2009–30 June 2011.

Results 485 Lothian children were discharged on HETF from the regional paediatric hospital (paediatric HETF) compared with 114 from the neonatal unit (neonatal HETF) over the same time period. Over the study period a rise in numbers requiring paediatric HETF was observed (average of 34 per year in 2000–2005 increasing to 55 per year in 2006–2011), however there was a decreasing number requiring neonatal HETF (average of 16 per year in 2000–2005 decreasing to 8 per year in 2006–2011). HETF was primarily used short term in the neonatal group for immaturity alone. During the 2-year period of the study 7/2009–6/2011, 20 neonates were transferred to the regional paediatric unit on ETF; 11 (55%) were subsequently discharged on HETF from the paediatric unit, but these neonatal transfers only accounted for 10% of the total of 103 paediatric HETF discharges.

Conclusion These novel data firstly demonstrate that the incidence of HETF usage on discharge from a UK paediatric regional centre continues to increase while that from the neonatal unit serving the same region is falling, and secondly that sick neonates transferred on ETF make up only a small number of incident paediatric HETF cases.

Competing interests None declared.

PMO-072 A 1 YEAR TWO PHASE PROSPECTIVE PROJECT LOOKING AT NUTRITIONAL RISK IN REACTIVE VS ELECTIVE NASOGASTRIC ENTERAL FEEDING IN HEAD AND NECK CANCER PATIENTS UNDERGOING RADICAL (CHEMO)RADIOTHERAPY

doi:10.1136/gutjnl-2012-302514b.72

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Introduction Pre 2009 head and neck cancer (HNC) patients requiring enteral tube feeding during radical (chemo)radiotherapy at our regional cancer centre were admitted reactively in a nutritional "crisis" and fed via a nasogastric(NG) tube.¹ Audit resulted in a 1-year service improvement grant for a Specialist Dietitian to proactively support HNC patients "from pre-treatment until rehabilitation is complete".² The aim of this 1-year (2009–2010) two-phase prospective project was to reduce nutrition related crisis admissions, malnutrition and refeeding syndrome, thereby reducing length of hospital stay (LOS) from an average of 13 days¹ while aiming to improve patient experience and outcome.

Abstract PMO-072 Table 1

	Total number of patients	Total patients admitted	% Patients at risk of refeeding syndrome on admission	Average number of days from admission until full nutritional requirements met	Average LOS days
Audit ¹ (2006–2008)	223	32	94	11 (SD±4.9)	13 (SD±5.1)
Phase 1	83	32	75	8.2 (SD±5.4)	9.3 (SD±6.1)
Phase 2	23	9	33	3.2 (SD±2.7)	4.3 (SD±5.2)
p Value (phase 1 & 2)			0.04*	0.01**	0.0065**

*Fisher's exact test, two-tailed.

**T-test, unpaired, two-tailed.

Methods Phase1 (9 months): All patients with HNC (squamous cell carcinoma) were included. Nutritional status (MUST score), %weight loss and swallow ability was recorded for all patients before, during and after radiotherapy treatment. Patients were admitted reactively with inadequate nutritional intake and/or 5% weight loss. Interim review of phase 1 highlighted that oral cavity, oropharyngeal, nasopharyngeal, hypopharyngeal carcinomas and unknown primary tumours were at nutritional risk from weeks 2 and 3 of radiotherapy, leading to reactive admissions for NG feeding. Phase 2 (3 months) involved patients with these tumours admitted electively for NG feeding in week 3 radiotherapy. All admitted patients were followed up for 6 months.

Results Refeeding risk, number of days until nutritionally fit and LOS were all significantly reduced in phase 2 compared to phase 1.

Conclusion This data demonstrates that when appropriately funded, a specialist dietetic service working as part of a multidisciplinary team in HNC, by electively admitting high nutritional risk patients for NG feeding, can significantly reduce clinical risk and costs. As a result of clinical benefits and cost savings our Trust made the service improvement funding substantive.

Competing interests None declared.

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PMO-073 POST-OPERATIVE ENTERAL NUTRITION AND RECIRCULATION OF JEJUNAL EFFLUENT IN THE MANAGEMENT OF A PARADUODENAL HERNIA: A CASE REPORT

doi:10.1136/gutjnl-2012-302514b.73

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Introduction Short gut secondary to surgical resection often requires post-operative total parenteral nutrition. We present a case of ischaemic gut secondary to a paraduodenal hernia. Post-operative nutritional requirements were met using enteral feeding via a feeding jejunostomy and recycling end jejunostomy effluent.

Methods Case: A female presented with abdominal pain and metabolic acidosis. A double contrast abdominal computer topography scan revealed necrotic small bowel secondary to an internal hernia into the right paraduodenal fossa. She was found to have 180 cm of infarcted jejunum and ileum. After resection of this segment an end jejunostomy was formed along with a closed mucus fistula from proximal ileum. 50 cm proximal to this a feeding jejunostomy/ileostomy was constructed. Early jejunal feeding with elemental feed was commenced on day 1. Loperamide and codeine were added to slow intestinal transit and promote absorption. On day 5, bile excreted via her jejunostomy was recycled via her feeding