jejunostomy. Her enteral feed was changed from elemental to modular on day 8 and sandostatin commenced. Her nutritional markers improved on this regime and despite having only 50 cm of jejunum proximal to her stoma, outputs were low and her electrolytes remained normal. She put on weight post-operatively and proceeded to closure of her stomas at 6 months.

Results N/A.

Conclusion Discussion: Internal hernias are rare and commonly present with small bowel obstruction. Paraduodenal hernias are the most common form and can be either left or right sided. Normal small intestinal length varies between about 275 cm to 850 cm with nutritional or fluid supplementation required for patients with <200 cm. This lady had a post-operative bowel length of 225 cm. The majority of gastrointestinal secretions are reabsorbed in the upper jejunum and patients with jejunostomies often have large volume stomal output. We used loperamide and codeine to slow intestinal transit, aid absorption and prevent fluid and electrolyte imbalance. Limited reports of bile-jejunostomy recycling were found in the literature and to our knowledge no cases have been reported of patients with short bowel being managed using recirculation of jejunal effluent and enteral nutrition in isolation. In this case, jejunostomy fluid was collected and immediately recycled via a feeding ileostomy eliminating the need for parenteral nutrition. Success was shown by improvement in nutritional status and weight gain.

Conclusion This case exemplifies the effective use of jejunostomy output recycling to reduce water and electrolyte loss and aid fat absorption in a patient with short gut thus preventing the use of parenteral nutrition.

Competing interests None declared.

PMO-074 A 10 YEAR RETROSPECTIVE REVIEW OF NASOGASTRIC TUBE USE IN A DISTRICT GENERAL HOSPITAL

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E Tash,* A Cartwright, L Steel, J Subhani. *Department of Gastroenterology, Basildon and Thurrock University Hospitals NHS Foundation Trust, London, UK*

Introduction A Nasogastric tube (NGT) is a commonly used device for administration of enteral feeding. It may be used as a bridge to a more definitive procedure (eg, Percutaneous Endoscopic Gastrostomy; PEG) or until patient recovery. The NPSA estimates that "thousands of NGT are placed each day" throughout the UK.¹ However, following a literature review we were unable to find any outcome data for this procedure.

Methods We performed a retrospective review of our nutrition database at Basildon and Thurrock University Hospitals NHS Foundation Trust, that serves a population of 375 000, for all patients who had an NGT inserted between years 2001 and 2011 and analysed the insertion reason and outcome.

Results Over a 10-year period, 2526 patients underwent 2715 episodes of NGT insertions, with a male to female ratio of 49.5% and 50.5%, respectively. The total number of feeding days was

50584, with a median and mean length of insertion of 10 and 18.7 days, respectively. 189 patients required a repeat NG feeding episode, either within the same or subsequent hospital admission. The referral reasons and outcome data are shown in the Abstract PMO-074 table 1 below.

Conclusion Data analysis revealed that two thirds of all NGT insertions were for patients with dysphagia secondary to a neurological condition, mechanical obstruction or artificial ventilation. Despite these patients being unwell and high risk for complications 46.9% were able to restart oral feeding. However, almost an equal number died while receiving NGT enteral feeding. 2.7% of our cohort were discharged home with some form of long term enteral feeding; either via a PEG or longterm NGT.

Competing interests None declared.

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PMO-075 30-DAY MORTALITY RISK FACTORS FOR PERCUTANEOUS ENDOSCOPIC AND RADIOLOGICALLY-INSERTED GASTROSTOMY

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F M Laskaratos,* M Walker, V Wojciechowska, A Jenkins. *Department of Gastroenterology, Princess Royal University Hospital, London, UK*

Introduction Gastrostomy insertion is of benefit in selected patients,¹ but 30-day mortality is as high as 54% in some patient groups.² Risk factors associated with early mortality include advanced dementia, age >75 years, serum albumin <30 g/l, C-reactive protein >10 mg/l, cardiovascular and respiratory comorbidities.^{3,4} The Sheffield scoring system has been developed to identify patients at risk of early death.⁵ The current study examines risk factors associated with 30-day mortality in a cohort of patients who underwent percutaneous endoscopic gastrostomy (PEG) or radiologically-inserted gastrostomy (RIG) in a district general hospital over a 12-month period.

Methods A retrospective review was made of case notes of all patients who underwent a PEG (n=26) or RIG (n=16) insertion in the period July 2010–July 2011. PEG/RIG re-insertions were excluded. Demographic, clinical and biochemical data were analysed.

Results The main indications for a PEG/RIG insertion were cerebrovascular accident (n=14), chronic neuromuscular disease (n=10), oropharyngeal malignancy (n=8), intracerebral pathology other than stroke (n=6), cognitive impairment (n=2), ICU neuropathy (n=1) and somatisation disorder (n=1). The overall 30-day mortality was 7/42 (16.7%). The main risk factors associated with 30-day mortality were age >75 years (p<0.05) and cardiovascular co-morbidities (p<0.01). The serum albumin, C-reactive protein and respiratory comorbidities were not associated with early mortality. There was no correlation between 30-day mortality and Sheffield score.

Abstract PMO-074 table 1

Reason for referral	Total episodes	Percentage of total (%)	Outcome of NG feeding	Total episodes	Percentage of total (%)
Dysphagia	1689	62.2	Restart oral feeding	1272	46.9
Malnutrition	635	23.4	Died	1208	44.5
Post operative GI tract	266	9.8	Transferred out of area	157	5.8
Miscellaneous*	69	2.5	Discharged home on enteral feeding	74	2.7
Post operative non GI tract	42	1.5	Self discharged	2	0.1
Increased nutritional requirements	25	0.9	Missing data	2	0.1

*Miscellaneous includes missing data (19 and 0.7); intestinal obstruction (16 and 0.6); intestinal failure (8 and 0.3); malabsorption (4 and 0.2) and NG feed during the course of an episode of acute pancreatitis (22 and 0.8).

Conclusion In keeping with other studies, age >75 years and cardiovascular co-morbidities were associated with 30-day mortality after gastrostomy insertion. However, other previously identified risk factors did not correlate with early mortality in this group of patients.

Competing interests None declared.

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PMO-076 ASSESSMENT OF THE PROBIOTIC SYMPROVE IN PATIENTS WITH IBS: A RANDOMISED DOUBLE BLIND PLACEBO CONTROLLED TRIAL

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¹I Bjarnason, ¹G Sisson,* ²S Ayis. ¹Department of Gastroenterology, King's College Hospital, UK; ²Department of Primary Care and Public Health Sciences, King's College London, London, UK

Introduction Treatment of patients with Irritable Bowel Syndrome (IBS) is often difficult, empiric and not evidence based. Recent insights into the pathogenesis of IBS have suggested that intestinal bacterial dysbiosis may result in symptomatic IBS. Accordingly, there is considerable interest in new treatments centred on modifying the intestinal bacterial flora with antibiotics or administration of appropriately designed probiotics. Therapeutic efficacy of probiotics appears to be strain specific. Symprove is a liquid probiotic formulation containing four bacterial strains (*Lactobacillus casei*, *acidophilus* and *plantarum* as well as *Enterococcus faecium*) with a shelf life in excess of 3 months. We assessed its efficacy in patients with IBS.

Methods Material and Methods: This was a single centre, double blind, randomised, placebo controlled trial involving treatment with Symprove (1 ml/kg body weight) vs placebo for 3 months. Patients were recruited from two large GP practices and from GP referrals to the Department of Gastroenterology at King's College Hospital. All patients had failed conventional first and second line treatment by GP's. An initial 391 patients were screened for the trial and 186 were eligible and consented to the trial (fulfilled ROME III criteria, exclusion of organic disease by extensive investigation including intestinal permeability, faecal calprotectin, endoscopy, wireless capsule endoscopy, colonoscopy and radiology when indicated). Using the Mersenne twister pseudo-random number generator 124 received the active treatment and 62 placebo. The main outcome measure was the reduction in IBS symptom severity scores (IBS-SSS) at 3 months. All patients were symptomatic with IBS-SSS >150.

Results There were no significant differences between the two treatment groups with respect to demographic details (male/female ratio, mean age, duration of disease or previous treatment). There were no significant differences ($p>0.1$) at pre treatment IBS-SSS scores between active (303 ± 68 , mean $\pm$ SD) and placebo (306 ± 80) ($p=0.841$) treated patients. During the last week of treatment (week 12) there was a statistically significant ($p<0.027$) greater improvement in the mean IBS-SSS (230 ± 109) in the Symprove treated

patients as compared with placebo (270 ± 103). The number of dropouts during the study did not differ significantly between the two groups and no severe adverse events were evident.

Conclusion Three months treatment with the probiotic Symprove was associated with significantly greater reduction in symptom severity in patients with moderate to severe IBS as compared with placebo.

Competing interests I Bjarnason grant/research support from: 3 year grant for MD student from the manufacturers of symprove, G Sisson grant/research support from: received 3 year salary from the manufactures of symprove, S Ayis: None declared.

PMO-077 HOME ENTERAL TUBE FEEDING (HETF): A CASE BURDEN FOR THE PAEDIATRIC EMERGENCY DEPARTMENT (PED)?

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¹J Smith,* ²C Paxton, ³P Leonard, ^{2,4}D Wilson. ¹Department of Paediatrics, Royal Hospital for Sick Children, Edinburgh, UK; ²Department of Paediatric Gastroenterology, Hepatology and Nutrition, Royal Hospital for Sick Children, Edinburgh, UK; ³Department of Paediatric Emergency Medicine, Royal Hospital for Sick Children, Edinburgh, UK; ⁴Department of Child Life & Health, University of Edinburgh, Edinburgh, UK

Introduction The contribution of HETF issues to PED workload is poorly understood. We aimed to evaluate PED attendance records of children receiving HETF (rates, presenting complaints and outcomes). We also aimed to assess possible trends between timing of attendances and hours of service provided by our Children's Community Nursing (CCN) team.

Methods We searched 114 606 attendances to PED from April 2008 to March 2011, reviewed all those involving cases on HETF, and correlated with our regional paediatric nutrition support team (NST) records. Day, time and month of attendance plus the presenting triage complaint and outcome were noted. Descriptive results are presented with day of week attendance analysed by the z-test.

Results There were 364 attendances of 183 patients with a mean (SD) annual point prevalence of HETF patients attending the PED of 23(3.1)%. Mean (SD) attendance rates were 121.3 (23.9) per year representing 61.0(5.2) patients. Presenting complaints included gastrostomy tube (GT) removal (29%), nasogastric tube (NGT) removal (27%), jejunal tube (JT) removal (5%) hardware fault (6%), tube blockage (12%), infection (9%), leakage (4%), malposition (5%) or other (3%). 324 (89%) patients were discharged home and 36 (11%) admitted, mostly for surgical reinsertion. More patients attended on Sundays than any other day of the week ($p=0.045$); December and January were the busiest months. Peak attendance time was 17:00–18:00; 43% attended out with CCN service hours (08:00–18:00). Most NGT and GT (64%) were reinserted in PED by medical, surgical or nursing staff. Imaging (fluoroscopy; chest x-ray) was required in 29 patients. Topical or enteral antibiotics were prescribed for 22 patients. No action or a simple flush was required in 24 and eight returned the following morning for placement. 20 repair kits for hardware problems were used.

Conclusion Over 20% of HETF attend PED annually with feeding tube-related problems; 43% attend out with CCN service hours. Significantly higher attendance rates on the day without CCN service cover highlights a flaw in this service design, given the simple problems that occur usually do not need PED expertise and resources.

Competing interests None declared.

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