Results 492 CA19.9 assays were performed in 12 months. 245 were in patients who had not had abdominal imaging or LFTs measured. 247/492 had both imaging and LFTs and were included in the initial analysis. 102/247 had a positive CA19.9. A total of 45/247 were found to have a pancreatic or biliary malignancy 38/45 had a positive CA19.9. This was negative in 7/45. The overall clinical utility of CA19.9 was poor. From the 492 assays performed during the year a positive CA19.9 was associated with a new malignancy in just 7% (38/492). Overall 63% of patients with a positive CA19.9 did not have pancreatic cancer (PPV 37%). Conversely 5% of those with a negative result did (95% NPV). 22% of patients with pancreatic malignancy had normal LFTs at the time of diagnosis. In total 103/492 (20%) of assays were duplicates. Only 36/103 (35%) were in patients with confirmed malignancy. 67 assays were requested in patients with normal abdominal imaging or in the absence of imaging and LFTs. The total cost for all assays was £7380. £6165 was spent on inappropriate requests or where the diagnosis was not pancreatic malignancy.

Conclusion The clinical utility of CA19.9 is poor with only 7% of samples resulting in a new diagnosis of pancreatic malignancy. The assay is frequently requested inappropriately, often without abdominal imaging being available. LFTs should not be used to guide testing. CA19.9 measurement should only be undertaken in patients where imaging results are available and suggestive of pancreatic malignancy. There are significant cost savings from this approach.

Competing interests None declared.

PTU-253 LIFE WITHOUT A BLEEDING ROTA: RISK OF LATE ENDOSCOPY?

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Introduction In the 2007 UK audit of acute upper gastrointestinal bleeding (AUGIB),¹ 44% of participant centres did not have facility for a dedicated bleeding rota. Gross measures of outcome, such as mortality, were found to be independent of the presence of a bleeding rota; however adherence to other aspects of guidance, such as time to endoscopy, in the absence of a bleeding rota, was not examined. We aimed to examine the performance in the absence of a dedicated bleeding rota, but with a "goodwill" out of hours service, against national guidelines and performance.

Methods Data were collected prospectively for all cases of AUGIB over a 2-month period from September 2010 to November 2010. Cases were identified from request forms in the endoscopy department. Data were collected for all endoscopies; repeat endoscopy on the same admission was recorded separately. Rockall score, if not included with the original endoscopy request was calculated retrospectively. Results were analysed in Excel. Statistics performed using Fischer's exact test.

Results There were 35 patients identified, referred for 40 procedures for AUGIB, 39 of which were carried out. Median age at presentation was 64 (35–92), 14 years younger than the national audit. The proportion of patients presenting with documented cirrhosis 23% (n=8) was significantly greater than in the national audit p=0.0026. Furthermore the proportion of patients with varices, although not necessarily responsible for the bleed, was greater 17% vs 8% p=NS. Rockall score was documented in 23% cases compared with 19% in the national audit. Rockall score was ≥ 3 in 73% compared with 51% in the national audit p=0.01. Time to endoscopy, regardless of Rockall score was <24 h in 72% and in patients with Rockall score ≥ 3 was 79% compared with 50% in both groups in the national audit. In the cases in our study for whom the Rockall score was

documented, all had a Rockall score ≥ 3 and proceeded to endoscopy within 24 h. Mortality in both our study and the national audit was 10%.

Conclusion Our patient group was younger than the national average with a higher proportion with pre-endoscopy Rockall score ≥ 3 . We demonstrate ongoing difficulties in encouraging documentation of risk assessment scores, however in our experience when the Rockall score was documented the endoscopy happened in a timely fashion. We demonstrate with data from our centre that early endoscopy is achievable in the majority of cases in the absence of a dedicated bleeding rota. This does not appear to affect overall mortality however risk assessment and early endoscopy are important as we strive to improve the service we offer our patients.

Competing interests None declared.

REFERENCE

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PTU-254 WHAT DO GENERAL PRACTITIONERS WANT FROM GASTROENTEROLOGY SERVICES IN SECONDARY CARE, AND WHAT ARE THEY HAPPY MANAGING IN PRIMARY CARE?

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Introduction Recent changes in the NHS have focussed on moving more services into primary care. General Practitioners (GPs) are rarely consulted over planning of secondary care services, nor are they asked on their own comfort in managing gastroenterological conditions. The results of a GP survey of confidence and service development are presented.

Methods An online survey (created on Google Docs) was emailed to 102 GP practices. GPs were asked to rate their confidence in managing gastroenterological conditions as well as rate service developments using a 5-point Likert scale (1—very low, 5—very high). Free text boxes allowed GPs to provide additional comments for qualitative analysis. Responses (n=52) within 28 days were analysed in Microsoft Excel.

Table 1. GPs confidence in managing Gastroenterological conditions

Condition	Average	Median
Dysphagia	4.00	4
GORO and Dyspepsia	4.00	4
Iron Deficiency Anaemia	4.00	4
Gall Stone and Biliary Disease	3.93	4
Functional GI problems	3.87	4
Weight loss	3.78	4
Acute and Chronic Diarrhoea	3.75	4
Abdominal Pain	3.71	4
Gastrointestinal malignancies	3.58	4
Acutely Deranged LFTs	3.35	4
Patients on Immunosuppressants	3.33	4
Inflammatory Bowel Disease	3.33	4
Alcohol Dependency Syndrome	3.05	3
Malabsorption and Nutritional Problems	3.00	3
Chronically Deranged LFTs and Cirrhosis	2.79	2
Chronic Pancreatitis	2.26	2