symptoms. A similar cohort was identified with age & sex matched controls with FC values <50 µg/g. All the patients who did not go on to have a complete colonoscopy were removed from further analysis. Patients' records were analysed electronically using the NHS Great Glasgow & Clyde Clinical Portal.

Results 216 patients were identified with a FC of 50–100 µg/g. After exclusion criteria, 158 patients remained. Of these 82 underwent complete colonoscopy (mean age 36.7, M:F 1:2.2) which was abnormal in only six cases (three cases of a single adenoma <10 mm, one diverticulosis, one helminth infection & one non-specific acute inflammation). 280 patients were identified with a FC <50 µg/g. After exclusion criteria, 176 patients remained. Of these 65 underwent complete colonoscopy (mean age 36.6, M:F 1:2.3) which was abnormal in only eight cases (six cases of non-specific acute inflammation, one adenoma <10 mm & one diverticulosis). The colonoscopy outcome data, as expected, demonstrated that the pathology rate was very low in both groups. There was no difference in the rate of pathology detection between to two groups ($p=0.3$) and an FC <100 µg/g has an NPV of 88% to exclude any pathology or 100% for significant pathology (IBD, advanced adenoma or colonic carcinoma).

Conclusion In our population, the diagnostic yield of colonoscopy in patients below the age of fifty with new lower GI symptoms and a mildly elevated FC is very low. If our data can be replicated in a prospective manner, we suggest that invasive colonoscopy can be safely avoided in this cohort and interval FC analysis may be more appropriate.

Abstract PMO-015 Table 1

Any pathology	Diagnosis		IBD, advanced adenoma or carcinoma	Diagnosis	
	+ve	-ve		+ve	-ve
FC 50–100	6	76	FC 50–100	0	82
FC <50	8	57	FC <50	0	65
Sensitivity	42.9		Sensitivity	0	
Specificity	42.9		Specificity	44.2	
PPV	7.3	χ^2 test	PPV	0	
NPV	87.7	$p=0.3$	NPV	100	

Competing interests None declared.

PMO-016 BIG BROTHER IS WATCHING YOU! IS DATA FROM THE BSG COLONOSCOPY AUDIT PERIOD A TRUE REFLECTION OF NORMAL PRACTICE?

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Introduction The “Hawthorne Effect” is the phenomenon in which subjects modify practice as a consequence of the knowledge that they are being observed. This is a potential confounder during periods of national endoscopy audit and may result in spuriously improved outcome reporting during audit periods. We aimed to investigate whether the Hawthorne Effect influences colonoscopy practice. We also aimed to ascertain if the national colonoscopy audit could result in a change in practice, and whether any such change was maintained.

Methods The Unisoft endoscopy database at Whipps Cross University Hospital was interrogated to determine patient demographics, sedation rates, quality of bowel preparation, diagnoses and therapeutic interventions during 5 2-week time periods; The national colonoscopy audit period (t), t–1 year, t–2 weeks,

t+2 weeks and t+3 months. Results were compared to determine whether there was a statistically significant difference in measurable indices of clinical practice that may be due to the Hawthorne Effect. Time periods following the audit period were included to establish whether there was any evidence of a “washout period” of improved outcomes following the national audit—that is, if the process of observed audit results in a lasting improvement in clinical practice. The null hypothesis was suggested that all periods would be similar, and tested to a 95% confidence level.

Results Colonoscopies performed during the national colonoscopy audit period (t) were compared with 2-week periods t–1 year, t–2 weeks, t+2 weeks and t+3 months. Similar numbers of procedures were carried out during the five time periods. Basic patient demographics were similar, as were the numbers of male and female patients. No statistically significant differences were found in the sedative dose, ceacal or TI intubation rates between the audit period and any other time period. Moreover, polyp detection and retrieval was likewise also not statistically significantly different when the four time periods were compared with the fortnight of the national colonoscopy audit. Small differences were noted in the colonoscopists assessment of bowel preparation—there was more likely be a comment on poor bowel preparation during the audit period than any of the other time periods.

Conclusion Data from Whipps Cross University Hospital demonstrate that observation of colonoscopists during the recent BSG national colonoscopy audit does not alter significantly the clinical practice or interpretation of findings when compared to time periods before or after the audit period. This validates the national colonoscopy audit findings; the data are indeed a true reflection of “normal” colonoscopy practice—colonoscopists are apparently not affected by the “Hawthorne Effect”.

Competing interests None declared.

PMO-017 PERINATAL HEPATITIS B IN A HIGH PREVALENCE INNER CITY POPULATION: DIRECT ELECTRONIC REFERRAL IMPROVES CARE

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Introduction There is little work evaluating perinatal Hepatitis B (HBV) care despite extensive recent guidelines from several sources. Seamless interaction between maternity and specialist clinical services is key to improvement of screening, education and patient care in HBV. We introduced a new electronic patient referral system (EPR) from Midwifery Services to Hepatology. We reviewed care provision and investigated the impact of EPR.

Methods Data were collected from the Kings College Hospital (KCH) Maternity Services Record and Liver Services Database for 6 months before and 6 months after introduction of EPR.

Results The burden of HBV in our patient group is high. Of 6796 women attending antenatal booking during the study, 101 tested positive for HBV exposure (1.5%). Liver services received referrals from Maternity for 84 women during the two time periods. Four women (4.8%) were HBsAg negative, HBcAb positive. The majority of patients were Black African (61%) followed by Chinese (23%) then Eastern European (8%). 66% had no previous Hepatology contact and represent new diagnoses. 11.4% tested eAg positive (n=9) of whom only two had HBV DNA checked antenatally and were started on Tenofovir therapy due to viral loads >10⁶ IU/ml.

Two HBeAg +ve patients attended booking too late to be eligible. Neonatal active and/or passive immunisation was recommended appropriately in all cases. Referral rates for eligible patients doubled following introduction of EPR. In the initial 6 months 32% of patients testing HBsAg positive at Maternity Services were referred to Hepatology (n=16) compared to 63% (n=33) following introduction of EPR. Mean gestation at referral improved from delivery date +2 weeks compared to 27 weeks gestation. Measurement of antenatal HBV DNA improved from 33% of patients referred to 81%. No HBeAg negative patient who had HBV DNA analysis had a viral load $>10^4$ IU/ml. No patient had HBV DNA rechecked during pregnancy.

Conclusion Maternal seroprevalence in our population is high with most patients being new HBV diagnoses. An individualised liaison pathway for antenatal woman has improved service by:

Doubling referral rates to specialist services

Increasing potential access to third trimester Tenofovir if required

Increasing HBV DNA analysis rates without duplication of HBV DNA testing

To optimise preventative public health approaches to HBV wider use of this referral model should be considered in high prevalence settings. Education of the community and other health providers remains critical.

Competing interests None declared.

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PMO-018 DEDICATED SPECIALIST DIETETIC INPUT IMPROVES OUTCOMES FOR UGI SURGICAL CANCER PATIENTS

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Introduction Upper GI (UGI) cancer patients are at high risk of malnutrition increasing risk of complications post-operatively. Surgeons and Oncologists at Ninewells Hospital, Dundee funded an UGI Oncology Dietitian who oversaw nutritional care of patients through neoadjuvant chemotherapy, preparation for surgery and into follow-up. Previously at Ninewells, dietetic care of patients was ad-hoc resulting in reduced nutritional status during chemotherapy, admissions for feeding and delays to surgery. Once the post-holder joined the MDT it was important to show value for money and clinical effectiveness so data were gathered on outcomes for patients who had undergone UGI cancer surgery in the year before the post-holder started (n=49) and for 1 year afterwards (n=22).

Methods A literature search was performed using MEDLINE in order to compare results against other centres but no similar studies were found. Subsequently the MDT decided on clinical standards based on current evidence and acceptable limits including: Patients will be referred to the Upper GI Oncology Dietitian prior to surgery.

Patients will maintain their weight during chemotherapy and surgical admissions within 5%.

All patients will have a jejunostomy tube placed at the time of surgery.

Data were gathered from medical and dietetic notes for each group on; whether patient was referred before surgery, weight (kg) at start and end of chemotherapy and on admission and discharge

from surgery, whether jejunostomy placed at time of surgery, length of stay (LOS).

Results

Standard	Pre postholder	With postholder
% Of pts maintaining weight within 5% during chemotherapy	50%	93%
% Of pts maintaining weight within 5% during surgical stay	20%	59%
% Of pts referred to dietitian pre-op	72%	100%
% Of pts with jejunostomy inserted at surgery	95%	77%
LOS	27 days	22 days

Conclusion Results showed the positive and cost saving impact of a dedicated dietitian on standards measured especially during chemotherapy and on LOS. The number of feeding tubes inserted fell in the group with dietetic input reflecting the types of surgery performed. Improved communication and leadership between the dietitian and the MDT helped to prevent admissions for pre-operative feeding and reduce delays. Further large studies are required, particularly in the peri-operative period, to further promote dedicated dietetic input.

Competing interests None declared.

PMO-019 EVALUATION OF EVIDENCE-BASED RECOMMENDATIONS IN CURRENT BRITISH SOCIETY OF GASTROENTEROLOGY GUIDELINES

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Introduction Clinical practice guidelines aim to improve patient care. They are based on best available evidence and are frequently viewed as “gold-standard” care for the disease or intervention that they address. The aim of this study was to determine the overall quality of the evidence supporting current British Society of Gastroenterology (BSG) guidelines.

Methods Guidelines were retrieved from the BSG website on 6th January 2012. Those posted after 2006 were considered current. The quality of supporting evidence was graded in accordance with the systems initially used to assess the primary literature. Adherence to the BSG’s advice on guideline writing issued in 2010 was assessed in guidelines published thereafter.

Results 18 BSG guidelines currently exist addressing topics in endoscopy (n=7), luminal gastroenterology (n=8), and hepatology (n=3). Four guidelines published in the study period were updates of previous guidance. These were published a median of 7.5 years after the initial guidance. Of a total of 434 evidence-based recommendations the quality of evidence was low in 42.8% (range 7.1%–85.7%), that is, from case studies or consensus opinions. High quality evidence-based recommendations (consistent data from randomised controlled trials) accounted for only 14.3% of all recommendations (range 0–45.5%). Overall, there was significant heterogeneity between guidelines. These were developed using four different evidence-grading systems. In those published since 2010 only one out of eight guidelines adhered to the evidence grading system advised by the BSG Clinical Services and Standards Committee.

Conclusion

1. Evidence-based recommendations in current guidelines are most frequently based on low quality evidence, reflecting a lack of available high quality evidence.