referrals were recorded on paper and filed in a secure office in the Department. We introduced an electronic database system to record a standardised dataset from each call in order to improve clinical governance and to generate contemporaneous records that could be easily retrieved and audited. We present our five-month pilot data.

Methods A Caldicott-compliant database was designed and made securely available to Registrars and Consultants. Registrars were encouraged to record all referrals and telephone calls they received. Calls taken by the Liver Intensive Care Unit, consultants, nurses, junior doctors and the out of hours team were excluded. Demographic and clinical data were recorded in real time with information regarding the source of the referral and the outcome of the call. There were no mandatory fields.

Results Data from 350 calls were entered over five months. The source of the call was recorded in 345 cases. 125 (36%) were from King's College Hospital and 20 (6%) were from General Practitioners or patients. The remaining 200 calls came from 75 institutions. Of the 220 calls made from outside the Trust, 63 resulted in the patient being transferred ($n = 32$), reviewed as an out-patient ($n = 27$) or discussed at a multidisciplinary team meeting ($n = 4$) at King's.

In 235 cases, discussion with a King's Consultant was recorded (67%). Of the 115 calls where discussion with a Consultant was not recorded, 41 were from within King's, 19 were transferred to King's and in 36 cases there was continuing input by telephone advice from one of the teams at King's. Only 15 extramural cases (7.5%) were concluded without a documented discussion with a Consultant.

Conclusion Use of an electronic database to record extramural telephone advice given by senior trainees and Consultants provides clinical governance to this service and forms a contemporaneous record that is kept at the referral centre. The data can be used to estimate workload and to determine the disease burden in this population, thereby tailoring services to the needs of referrers and commissioners. Formal recording of the Consultant input in the advice service also forms an excellent training opportunity for trainees. We recommend the implementation of similar databases in other units that give verbal advice to colleagues outside their own institution.

Disclosure of Interest None Declared.

Small bowel

PTH-179 AN AUDIT OF CLINICAL OUTCOMES OF SEHCAT STUDY IN PATIENTS WITH CHRONIC DIARRHOEA

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Introduction Latest NICE guidance suggest that there is not enough evidence to determine whether SeHCAT test is a cost effective option for diagnosing bile acid malabsorption (BAM) among people with IBS-D and Crohn's disease patients without ileal resection. We undertook an audit of sequential patients referred for SeHCAT testing to assess diagnostic value.

Methods Retrospective data was collected from 88 consecutive patients referred to Nuclear Medicine for SeHCAT testing over one year. The indication for the test request and treatment given were collected from request forms, clinic letters and GP record. Subjective global outcome was assessed at mean of 3 months after treatment (range 2–7).

Results Of 88 patients who underwent SeHCAT test, 49 (56%) were found to be positive for bile acid malabsorption. Of these 29 (59%) had severe ($< 5\%$ retention), 9 (18%) had moderate (> 5 and $< 10\%$ retention) and 11 (22%) had mild BAM (> 10 and $< 15\%$ retention).

With regard to the distribution of positive SeHCAT test results according to aetiology, there were 18 patients who fell into BAM Type

1 (Ileal disease/resection) group out of which 17(94%) were positive. Type 2 (Idiopathic BAM) had a total of 57 patients out of which 24(42%) were positive and Type 3 (Secondary to other GI disease) had 13 patients of which 8(62%) tested positive to SeHCAT study.

Table 1 below shows the outcomes of bile acid sequestrant (BAS) according to BAM groups.

Abstract PTH-179 Table 1

BAM type	Treatment	Outcome mean 3 months	
Type 1 ($n = 17$)	Started (12), dose increased (3), same dose (2)	Better 12	No change 3 Drug not tolerated 2
Type 2 ($n = 24$)	Started (16), dose increased (2), same dose (5), declined (1)	Better 11	No change 7 Drug not tolerated 6
Type 3 ($n = 8$)	Started (7), dose increased (1)	Better 4	No change 2 Drug not tolerated 2

39/88 (44%) patients had a negative test. Diagnoses were made as follows: IBS-D 13, inflammatory bowel disease with no BAM 8, functional or non-specific diarrhoea 18. In these patients BAS was empirically started, in spite of the test results, in 6, 2 and 5 patients respectively. Only 1 of these 13 (8%) patients (who had IBS-D) improved.

Conclusion Changes in treatment as a result of the SeHCAT test were made in 70% (62/88) of all patients: 84% (41/49) positive patients and 33% (13/39) negative patients. In terms of yield of SeHCAT, patients with chronic diarrhoea and ileal disease (BAM Type 1) may warrant empiric BAS treatment without testing since there was 94% response, suggesting limited value in terms of yield of new information. In contrast, there was value to a negative study, which predicted lack of response (8%) to BAS.

Disclosure of Interest None Declared.

PTH-180 SMALL BOWEL ULTRASOUND AND VIDEO CAPSULE ENDOSCOPY: COMPLIMENTARY INVESTIGATIONS TO DIAGNOSE SMALL BOWEL CROHN'S DISEASE

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Introduction Crohn's disease affecting the small intestine requires accurate localization, assessment and follow up, to direct and monitor therapy. Video capsule endoscopy (VCE) has an established role in small bowel Crohn's evaluation; however, use is limited by procedure costs and risks of capsule retention. Small bowel ultrasound (SB USS) with doppler is a rapid, inexpensive, dynamic and non-invasive method for assessing activity of Crohn's disease. We present the largest published comparative UK dataset of SB USS and capsule endoscopy in Crohn's disease.

Methods A 5 year retrospective analysis from 2008–2012 was carried out. Patients investigated for suspected small bowel Crohn's disease with SB USS and VCE were included, if one examination occurred within 12 month of the others. VCE findings were graded as mild (apthous ulcers only), moderate (apthous ulcers with mucosal distortion) or severe (apthous ulcers with mucosal distortion and strictures/stenosis). SB USS was graded positive or negative for small bowel Crohn's disease. Both assessments were single operator. Results were expressed as sensitivity, specificity, positive and negative predictive value (PPV and NPV) of SB USS compared with VCE for detection of small bowel Crohn's. Sub-analysis of SB USS findings for VCE-defined severity of small bowel Crohn's disease was carried out.

Results 500 VCE procedures were reviewed, of which 61 fulfilled the inclusion criteria. 19 patients had SB Crohn's on VCE; this was detected in 5 patients by SB USS (sensitivity 26%). 42 patients had no evidence of SB Crohn's on VCE; none of these had SB USS findings (specificity 100%). 56 patients had a negative SB USS, of these