Abstract PTH-039 Table 1 Summary of complications

	Before protocol	After protocol				Number (%)
	Number (%)	NSAID (102)	no NSAID (62)	PD stent (17)	no PD stent (163)	
Pancreatitis	2/67 (3)	5	0	1	5	6/180 (3)
Perforation	0/67 (0)	1	0	0	3	3/180 (1.5)
Bleeding	2/67 (3)	2	0	0	3	3/180 (1.5)
Admission	7/67 (10)	10	1	1	10	11/180 (6)

224 amylase tests were performed on 139 patients. 27/139 patients had abnormal amylase ($>1.5\times$ upper limit normal (ULN) at 2–4 h or $3\text{--}5\times$ ULN at 4–6 h). 14 were asymptomatic, 3 patients were admitted. Remainder with mildly abnormal amylase were managed without admission after clinical assessment.

There were total 8 cases of pancreatitis (3.2%), all associated with significantly raised amylase, apart from one (inpatient) case with a late rise at 48 h. Pre-protocol, 1 patient developed pancreatitis after discharge from day case.

NSAID use rose from 0 to 57% (14% contraindications), with no increased bleeding associated. PD stent insertion rose but remained infrequent, limited by technical feasibility. Pancreatitis rates did not significantly differ with prophylactic measures. **Conclusion** This audit demonstrated the real-life practice of ESGE guidelines to assess for and reduce ERCP-related complications. Amylase measurement was feasible – raised levels correlated with PEP but 1 case had normal early amylase. The few admissions with asymptomatic raised amylase is offset by avoiding emergency admission with PEP. In this small study NSAID and PD stent did not improve complication rates and remain under-utilised, but likely will increase as experience grows.

REFERENCE

- 1 Dumonceau JM *et al.* European Society of Gastrointestinal Endoscopy (ESGE) guideline: prophylaxis of post-ERCP pancreatitis. *Endoscopy* 2010;42:503–515

Disclosure of Interest None Declared.

PTH-040 USING NICE CRITERIA TO ASSESS THE MANAGEMENT OF ACUTE UPPER GI BLEEDS DURING WEEKENDS – THE EXPERIENCE OF A DISTRICT GENERAL HOSPITAL

I Al Bakir*, S Oke, T Rashid, SM Greenfield. *Gastroenterology, East and North Hertfordshire NHS Trust, Welwyn Garden City, UK*

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Introduction The management of acute upper GI bleeds (AUGIB) comes under greatest stress at weekends; this is a topical concern given the national drive towards a 7 day working week. We previously described the development of a centralised cross-county out of hours endoscopy service.¹ We aim to critically appraise this service against NICE guidelines (CG141) and quality standards (QS38) for the management of AUGIB.

Methods Our computer-based endoscopy database was retrospectively analysed to identify patients undergoing gastroscopy (OGD) for AUGIB during the weekend in 2012. Full demographic information and OGD reports were identified in all 95 cases; complete patient records were located for 66 (69%) patients.

Results The average patient age was 71. 66% were new episodes of AUGIB: the rest had AUGIB during admission with different pathology. 11% (10) of patients did not survive their admission. 81% (76/95) had significant diagnoses on OGD. Of note, 38% (36) of patients had peptic ulcer disease, 8% (7) had cancer and 5% (4) had varices.

While 86% (57/66) of patients received a pre-endoscopy Rockall score, 11% had full Rockall scores, and only 3% had a Blatchford score documented. 55% (37) of patients underwent transfusion; half were overtransfused to a Hb >10 g/dL. Correction of coagulopathy was adequate in 4 of 6 patients. Platelet and recombinant factor VII use was in keeping with NICE guidance. 36% of patients inappropriately received intravenous PPI prior to OGD. Only 1 of 5 patients with suspected variceal bleeding received antibiotics and terlipressin at presentation.

6% (4/66) of patients remained haemodynamically unstable despite resuscitation – all had OGDs within four hours of admission. 88 and 95% of patients underwent OGDs within 24 and 48 h of admission respectively. The main reasons for delays were lags in submitting OGD request forms and inadequate fasting, rather than a lack of endoscopy capacity. All patients received appropriate endoscopic therapy modalities, and timely repeat OGDs or surgical intervention when warranted. All patients on aspirin for secondary prevention of vascular events were recommenced on aspirin when haemostasis was safely achieved.

Conclusion The trust provides a comprehensive out of hours endoscopy service, particularly for emergency cases with persisting haemodynamic instability. There remains scope for further improvement in pre- and post-endoscopy care. This exercise highlights the use of NICE-generated standards in guiding service development, and can be replicated in most district general hospitals.

REFERENCE

- 1 ShokouhiBN *et al.* The setting up and running of a cross-county out-of-hours gastrointestinal bleed service: a possible blueprint for the future. *Frontline Gastroenterol* 2013;4:3 227–231

Disclosure of Interest None Declared.

PTH-041 A HIGH QUALITY TRANSIENT ELASTOGRAPHY SERVICE CAN SUCCESSFULLY BE DELIVERED BY HEALTHCARE ASSISTANTS

I Patanwala*, S Fielding, K Akerboom, J Barr, T Cross, M Lombard, P Richardson, H Caldwell. *Liver Unit, Royal Liverpool University Hospital, Liverpool, UK*

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Introduction Surrogate assessment of liver fibrosis by means of liver stiffness measurement (LSM) by transient elastography is well validated in different cohorts of patients with liver disease and is now a part of routine hepatological practice. There is an increasing demand for LSM in view of its role in managing patients with dermatological or haematological conditions who are on potentially fibrogenic therapy. Referrals for LSM in our unit have increased significantly over the last 12 months. Traditionally, specialist liver nurses have been trained to deliver this service. However, LSM by transient elastography is an easily transferable skill and therefore in a bid to reduce waiting times and make the service as cost effective as possible, we trained