Audit T121–T124

T121

A STUDY OF ADMISSIONS AND DEATHS DUE TO LIVER DISEASE IN A DISTRICT GENERAL HOSPITAL REMOTE FROM A TRANSPLANT CENTRE

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The profile of liver disease admissions and associated deaths in a District General Hospital was studied to determine whether patients with end-stage liver disease are appropriately referred for consideration of liver transplantation. Admission details were provided by the Office of Population Censuses and Surveys (OPCS). Accuracy of OPCS data was assessed by casenote analysis.

According to OPCS, 77 patients were admitted on 113 occasions with liver disease between January 1st 1987 and December 31st 1989. Casenotes of 74 (96%) were retrieved and examined. Only 64 (86%) had primary liver disease. 24 (31%) died of liver failure. Alcohol was the aetiological agent in two thirds.

According to accepted criteria, 11 patients were suitable for liver transplant assessment. Only 3 had been referred to a transplant centre. Of the 8 potential transplant candidates not referred, 5 died during the study period. Of the 3 patients referred, 2 died without transplantation, one was transplanted and survived.

Discrepancy existed between OPCS data and true disease aetiologies, with approximately 40% under-reporting of alcoholic liver disease.

If this population is representative of the situation nationally, substantial numbers of patients with end-stage liver disease might benefit from liver transplantation, but are not referred for consideration of such.

T123

A PROSPECTIVE AUDIT OF PATIENTS PRESENTING WITH IRON DEFICIENCY ANAEMIA AND FAECAL OCCULT BLOOD LOSS

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There have been relatively few reports of the assessment of patients referred to gastrointestinal (GI) units for investigation of iron deficiency anaemia (IDA).

89 patients (mean age 61; 62% female) with IDA and positive faecal occult blood presented between 1989 and 1991. Iron deficiency was confirmed by microcytic anaemia (MCV <80) with a serum ferritin <10ng/l or an appropriate response to iron therapy.

51 GI abnormalities were found in 45 patients, but not all were thought to be the cause of IDA. 82 patients were gastroscoped, 32 having significant pathology: Barretts ulcer (1), oesophagitis (8), gastric cancer (5), gastric ulcer (1), gastric erosions (12), gastric polyp (1) and duodenal ulcer (4). Duodenal biopsies were performed in 43 patients and revealed villous atrophy in 2.

69 barium enemas were performed and deomonstrated 15 abnormalities (12 cancers, all proximal to the splenic flexure, 2 ulcerative colitis and 1 colonic polyp). 20 colonoscopies were done usually because barium enema and gastroscopy revealed no acceptable cause in patients with evidence of continuing GI blood loss. Colonoscopy failed to demonstrate any further malignant lesions, but did reveal one case of Crohn's disease and one angiodysplasia.

Small bowel radiology performed in 18 patients failed to demonstrate any cause for IDA.

5 patients with colonic carcinoma had co-existing upper GI lesions: Barretts ulcer (1), oesophagitis (2) and erosive gastritis (2). The anaemias of 2 of the 12 patients found to have colonic cancer were initially thought to have been caused by severe oesophageal disease.

We conclude that although dual pathology is not particularly common, the risk of missing colonic cancer is sufficient to justify barium enema in addition to gastroscopy and duodenal biopsy as first line investigation of these patients.

T124

CHANGING PATTERNS IN THE SURGICAL MANAGEMENT OF CARCINOMA OF THE STOMACH

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The records of 31,716 patients registered with the West Midlands Cancer Registry between 1957 and 1981 were reviewed by quinquennium to determine the influence of improved diagnostic facilities and peroperative care in the management and prognosis of gastric carcinoma.

There was a consistent increase with time in the percentage of patients with a premortem histological diagnosis (57 - 61 = 42.9%, 77 - 81 = 64.5%) due to the increased use of endoscopy (62 - 66 = 1.8%, 77 - 81 = 35.1%). There was no significant change in the curative and palliative resection rate or incidence of non-treatment. Analysis by decennium (62 - 71 and 72 - 81) revealed a significant increase in the overall 30 day mortality (35.4 v 36.4% $p < 0.05$). This was associated with an increase in the curative resection rate (22.4 v 25.8% $p < 0.05$) and the age adjusted actuarial 5 year survival (excluding 30 day mortality) for stage I and II (39.4 v 44.9% $p < 0.05$) and stage III disease 10.5 v 13.2% $p < 0.05$).

Contemporary surgical management of gastric carcinoma is associated with a significant survival benefit. This improvement seems to reflect a more aggressive approach to investigation and curative resection at the expense of an increase in postoperative mortality.

T124

TITLE: USE OF RESOURCES BY PATIENTS WITH MALIGNANT GASTROINTESTINAL DISEASE UNDERGOING LASER TREATMENT.

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In a six month period 39 patients attended our unit for palliation of gastrointestinal cancer (26 oesophagogastric and 13 rectal carcinoma).

The median age of those with upper GI cancer was 71 (range 49-92). 13 patients were tertiary referrals. They required a total of 87 admissions (68 planned, 19 emergency) and 103 endoscopic procedures (12 laser + dilatation, 29 dilatation alone, 60 laser alone, 2 prosthetic tube insertions). Average bed occupancy was 21.1 nights (median 16, range 2-70) and median survival of these patients was 3 months (range 0-$>$24).

Median age of those with rectal carcinoma was 77 (range 60-91) and five of these were tertiary referrals. They needed a total of 45 admissions and 39 endoscopic laser treatments. Average bed occupancy was lower in this group at 10.1 nights (median 10, range 1-20) and median survival was higher at 6 months (range 1-$>$36).

Patients with gastrointestinal malignancy, particularly those with oesophageal disease, place a heavy demand on in-patient resources and this should be taken into account by clinicians planning palliative services.