PTU-244 AUDIT OF 30-DAY MORTALITY POST ENDOSCOPY—A TERTIARY CENTRE EXPERIENCE

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Introduction Post endoscopy mortality is a quality standard for all endoscopy units. Despite the BSG guidelines on endoscopy related mortality in 2006 there has been little published data available for individual trusts. To review all deaths occurring 30 days post Endoscopy performed within the UHL Trust and establish if they are related to the procedure. We also determined an all cause mortality and procedure related mortality for our Trust.

Methods Deaths that occurred both in hospital and community within 30 days post endoscopy were captured through our local CASE team for a period of 6 months (January—June 2009) and information was obtained on certified cause of death. All patients’ case records were critically reviewed. Data were collected on demographics, principal diagnosis, indication for procedure, nature and type of procedure, immediate complications and cause of death. We made an observation and established if the death was related to endoscopic procedure. Results are analysed using MS excel 2007 and SPSS V15.

Results In total 6783 endoscopy procedures were performed during this 6-month period. Of these, 5342 were Gastroscopies, 1645 flexible sigmoidoscopies, 1441 Colonoscopies and 355 ERCPs. A total of 87 patients died within 30 days of their Endoscopy procedure, a high proportion of which were inpatients. 56 died during their inpatient stay. 117 (72 OGD, 24 ERCP, 18 FOS, 2 Colonos and 1 EUS) procedures completed on these 87 patients were reviewed. Of these, 54 were therapeutic procedures. 53 were male and 34 were female with a median age 74 years. Of these 6 (5%) patients had three or more procedures, 26 (22%) patients had two procedures and 55 (73%) had single procedures. None required reversing agents nor had sedation related complications. One immediate complication of duodenal perforation following ERCP was recorded. Overall four deaths were identified to be causally related to Endoscopy, all of whom had therapeutic procedures (One OGD with oesophageal dilatation and three therapeutic ERCP (one of who died following a myocardial infarct)). 14 cardiovascular deaths occurred within 30 days post endoscopy, eight of which were within 8 days. Underlying malignancy was the commonest recorded cause of death in 30. Individual mortality rates 30 days post OGD, FOS, Colonoscopy and ERCP of 1.7%, 0.61%, 0.14% and 7.8% respectively were noted giving an overall mortality rate of 1.3% (1.78%). Individual procedure related mortality figures for OGD and ERCP are 0.03% and 0.56% respectively.

Conclusion Post endoscopy mortality is a safety and quality standard for all units. Our audit serves as a reminder of the appreciable risk associated with therapeutic endoscopy and that cardiovascular complications still account for a significant proportion of endoscopy related morbidity and mortality.

Competing interests None declared.

PTU-245 COMMUNITY BASED SPECIALIST GASTROENTEROLOGY CLINIC IN SHEFFIELD, UK—COMPARING PRIMARY CARE AND SECONDARY CARE BASED CLINICS 2010–2011

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Introduction Community based clinics may improve patients’ access to healthcare and improve communication between primary and secondary care.

Results In total 6783 endoscopy procedures were performed during this 6-month period. Of these, 5342 were Gastroscopies, 1645 flexible sigmoidoscopies, 1441 Colonoscopies and 355 ERCPs. A total of 87 patients died within 30 days of their Endoscopy procedure, a high proportion of which were inpatients. 56 died during their inpatient stay. 117 (72 OGD, 24 ERCP, 18 FOS, 2 Colonos and 1 EUS) procedures completed on these 87 patients were reviewed. Of these, 54 were therapeutic procedures. 53 were male and 34 were female with a median age 74 years. Of these 6 (5%) patients had three or more procedures, 26 (22%) patients had two procedures and 55 (73%) had single procedures. None required reversing agents nor had sedation related complications. One immediate complication of duodenal perforation following ERCP was recorded. Overall four deaths were identified to be causally related to Endoscopy, all of whom had therapeutic procedures (One OGD with oesophageal dilatation and three therapeutic ERCP (one of who died following a myocardial infarct)). 14 cardiovascular deaths occurred within 30 days post endoscopy, eight of which were within 8 days. Underlying malignancy was the commonest recorded cause of death in 30. Individual mortality rates 30 days post OGD, FOS, Colonoscopy and ERCP of 1.7%, 0.61%, 0.14% and 7.8% respectively were noted giving an overall mortality rate of 1.3% (1.78%). Individual procedure related mortality figures for OGD and ERCP are 0.03% and 0.56% respectively.

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Competing interests None declared.

Abstract PTU-243 Figure 1

Abstract PTU-243 Table 1

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<tr>
<th>Assay pairing</th>
<th>Grade of inflammation: inter-assay concordance</th>
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<tr>
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<td>All grades (n=29)</td>
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<tr>
<td>B/C</td>
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*p Value <0.02 by Fisher ratio.

Conclusion In this pilot, assays “I” and “C” had the most favourable characteristics/concordance. If this trend is confirmed by larger numbers, we will adopt the monoclonal assay “I” as it is automated.

Competing interests None declared.
A community gastroenterology clinic was established in Sheffield in 2011 to deliver out-patient care closer to patients’ homes while retaining access to specialist expertise. This study reports results from the first 8 months of the community clinic and compares with secondary care gastroenterology clinics.

**Methods** A single, weekly, consultant-delivered new patient community clinic (CC), designed as a “one touch”, single consultation, was established in primary care for a Consortium of 27 General Practices. Data for the study period, March 2011—October 2011, was retrieved for the CC from referral proformas, letters and primary care records. This was compared to secondary care clinics for patients referred from the same consortium during the study period and for the same time period the year prior to the CC (March 2010 to October 2010).

**Results** In March—October 2010, 579 patients from the consortium were seen in secondary care gastroenterology clinics. During March—October 2011, 596 patients were seen in gastroenterology clinics: 741 (82%) in secondary care and 155 (18%) in the newly established CC. Mean age was lower in the CC (50 vs 57.8 years, p<0.001), with 42/155 (27%) aged over 65 in the CC compared to 310/741 (42%) in the secondary care clinic (p<0.01). 67/741 (9.0%) patients did not attend appointments at the secondary care clinic compared to 9/155 (5.8%; p=0.15) in the CC. Median waits for CC appointments was 21 days at month 1 rising to 47.5 days in month 8. Presenting features were altered bowel habit (n=59 (38%)), abdominal pain (n=23 (15%)), reflux type dyspepsia (n=18 (12%)) and iron deficiency anaemia (n=16 (10%)). 144 patients (98%) attending the CC had had the specified pre-clinic investigations. 118/146 (81%) patients attending the CC were discharged back to the GP after one visit: of whom 111 (94%) had further tests recommended (33 blood tests, 56 gastroscopy, 53 colonoscopy, 16 ultrasound abdomen). In the 2010 period prior to the CC, 58/579 (6%) patients seen were discharged from their initial secondary care clinic review (p<0.0001).

**Conclusion** The new primary care gastroenterology clinic is associated with higher initial discharge rates, moving co-ordination of ongoing out-patient management to primary care. However, this was not associated with a reduction in patients seen in secondary care and attracted a younger cohort of patients. Additional follow-up is required to assess effects on overall healthcare resource utilisation.

**Competing interests** None declared.

**REFERENCE**