Conclusion A negative faecal calprotectin led directly to the avoidance of a colonoscopy in 12 patients and of small bowel investigation in 11 patients. Given the trust’s current tariffs for faecal calprotectin, colonoscopy and small bowel meal and follow through, a total cost saving of £7,194.59 was made. Avoiding further investigation by waiting for a negative faecal calprotectin would have resulted in a greater cost saving.

Disclosure of Interest None Declared.

REFERENCES

[PTH-138] ASSESSING THE POSITIVE PREDICTIVE VALUE OF PEPTIC ULCEARTION ON ENDOSCOPY FOR THE DIAGNOSIS OF HELICOBACTER IN A GENERAL POPULATION

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Introduction Helicobacter Pylori (H. Pylori) is a gramme negative bacillus. It is strongly associated with peptic ulcer disease and gastric cancer. 50% of the population aged over 50 may be infected with H. Pylori. The prevalence in 2008 was 30–40% in the UK adult population with pockets of higher prevalence associated with deprivation. Different diagnostic tests including 13C urea breath test, stool antigen test, serum antibodies to H. pylori and rapid urease (CLO) test are commonly used in current medical practice. Historical detection of H. Pylori in gastric biopsy specimens still remains the gold standard investigation for diagnostic purposes. Our study was to assess whether peptic ulceration at endoscopy should be used to determine Helicobacter testing or whether all patients referred for Gastroscopy with ‘non-reflux dyspepsia’ should be offered testing.

Methods It was a retrospective observational study analysing results of consecutive 172 patients who had CLO test performed (male 89, female 83) on a single user operator endoscopy list over a 4 months period (March to June 2010). CLO testing was carried out on the discretion of the endoscopist on any patient with unexplained ‘dyspepsia’ or endoscopic findings of peptic ulceration. Data on whether patients were on a proton pump inhibitor at the time of the endoscopy or concurrent use of non-steroidal anti-inflammatory drugs (NSAIDS) was not recorded.

Results Out of 172 cases, 34 cases were tested CLO positive (12/34 CLO positive patients had evidence of peptic ulcer disease on OGD); 138 cases were tested CLO negative of which 62/138 had evidence of peptic ulcer disease. Prevalence figure in our study matched with national UK figures i.e 43.02% (95% CI: 35.51% to 50.78%).

Conclusion Approximately 1/3 of patients found to be CLO positive had signs of peptic ulceration (35%). In the same cohort of patients nearly ½ of patients found to be CLO negative also had signs of peptic ulceration (45%). In our study using evidence of peptic ulceration (gastritis, duodenitis, gastric and duodenal erosions/ ulcers) as a guide as to whether a CLO test should be carried out is unhelpful. Caution has to be taken as we did not take into account data as to usage of PPI or NSAIDS. We suggest that presence of endoscopic findings should not be a sole determinant for Helicobacter testing.

Disclosure of Interest None Declared.

[PTH-139] A UNIQUE COMBINED GASTROENTEROLOGY/ RHEUMATOLOGY CLINIC: THE FIRST YEAR

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Introduction Articular problems affect many patients with inflammatory bowel disease (IBD) and joint symptoms are often difficult to control despite the therapeutic strategies aimed at controlling gut inflammation (1). Patients with inflammatory rheumatic conditions present a range of clinical problems to the gastroenterologist such as IBD, dysmotility, dysbiosis, liver dysfunction, nutritional problems and drug side effects. Patients often drift between the two specialties with inefficient communication and subsequent delay in a joined up approach to management. We therefore developed a joint gastroenterology/rheumatology clinic to improve the care of these complex patients and now report our experience of the first year.

Disclosure of Interest None Declared.