

We have audited the effects of these interventions individually and overall.

**Methods** We compared data from 2013 to 2011 to assess the impact of the intervention undertaken.

1. To assess the impact of the change in vetting guidelines, we measured the number of patients with ASA grade 3 or 4 who underwent colonoscopy.
2. To assess the impact of the change in patient information, we measured the number of sachets of Klean prep taken by patients and the assessment of the quality of bowel preparation.
3. To assess the impact of certain operators stopping performing colonoscopy, we measured the number of operators (excluding trainees) who performed >100 colonoscopies per annum and those with caecal intubation rate (CIR) >90%.
4. To measure the combined effect of the interventions, we looked at the combined CIR of all operators within the department.

## Results

**Abstract PTH-019 Table 1**

Measure	2011	2013	P value
Number	1563	1338	
Patients ASA grade 3 or 4	47 (3.01%)	33 (2.47%)	
Good/excellent bowel prep	1206 (77.16%)	192 (12.28%)	
Poor bowel prep	1060 (79.22%)	147 (10.99%)	
Mean dose of Klean prep	3.55	3.71	<0.0001
Operators >100 per annum	6 of 11	5 of 6	
Operators CIR >90%	7 of 11	4 of 6	
<b>Overall CIR</b>	<b>90.21%</b>	<b>94.54%</b>	<b>&lt;0.0001</b>

**Conclusion** All three interventions have caused improvements in measured outcomes. Fewer patients with significant co-morbidities are undergoing colonoscopy. The bowel preparation has improved and there is a statistically significant increase in the mean dose of Klean prep taken. The changes in the number of operators undertaking colonoscopy have allowed fewer operators to do more procedures. Intuitively, practice makes perfect and this along with the other interventions has significantly improved the combined CIR of all operators from 90.21 to 94.54% ( $p = <0.0001$ ).

The implementation of interventions outlined has been rewarding and is an exemplar to other endoscopy units on how to improve key quality outcomes of their colonoscopy practice.

**Disclosure of Interest** None Declared.

### PTH-020 RETROSPECTIVE COHORT STUDY TO DETERMINE THE OPTIMUM FREQUENCY OF SURVEILLANCE COLONOSCOPY FOR PATIENTS WITH INTERMEDIATE GRADE COLORECTAL ADENOMAS IN THE UK

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**Introduction** Colonoscopic surveillance for colorectal cancer (CRC) is widely practiced; however, there remains a lack of evidence to determine appropriate surveillance intervals for individuals at intermediate risk (IR) of CRC. Due to the considerable strain on endoscopic resources and serious cost implications, it is vital to optimise surveillance strategies to ensure colonoscopy is

targeted at those who will benefit most. This study examines the frequency of surveillance in patients with intermediate grade (IG) adenomas, aiming to assess whether there is significant heterogeneity in the detection of advanced neoplasia within this group, according to baseline findings and surveillance interval length.

**Methods** A retrospective cohort design was used in a secondary care setting. 18 UK hospitals were selected based on the availability of electronic patient data suitable for automatic extraction. Endoscopy reports containing Systematised Nomenclature of Medicine codes or words relating to adenomas were identified and linked to corresponding pathology records. These were extracted from hospital databases before being pseudo-anonymised, formatted and uploaded onto an APEX database to be interpreted and coded. Patients were excluded from the analysis if they had no IG adenomas, no baseline colonoscopy, any missing exam dates or conditions affecting CRC risk. Baseline and follow-up visits, and polyp characteristics, were defined using a series of rules developed by the study team. Outcome measures used were advanced adenomas (AA) and CRC; information on these was obtained using follow-up data from external sources, in addition to the hospital data.

Analysis of risk of AA and CRC at each follow-up visit, according to baseline findings and interval length, will be performed through the use of descriptive statistics and logistic regression.

Approval was obtained from the National Research Ethics Service, Caldicott Guardians and the National Information Governance Board. As it was not feasible to seek patient consent, patient confidentiality was ensured through pseudo-anonymisation of data.

**Results** Endoscopy and pathology data from over 200,000 patients was collected and coded, and a large bespoke database was created to store this data. A total of 11,995 IR patients with a baseline colonoscopy were identified for analysis, 4,694 of whom have at least one follow-up visit.

**Conclusion** Analysis of the data is currently in progress. When completed, later this year, conclusions will be drawn on the optimal surveillance intervals for IR patients. The database will also act as a unique resource for further studies involving patients at both low and high risk, and for examining the association between serrated lesions and proximal CRC.

**Disclosure of Interest** None Declared.

### PTH-021 NUTRITION ASSESSMENT IN THE ACUTE MEDICAL UNIT

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**Introduction** Malnutrition can increase hospital mortality rates, worsen clinical outcomes and increase the length of hospital stays. Those at particular risk include patients with cancer, gastrointestinal and neurological disease. We wanted to review whether patients admitted to the Acute Medical Unit were adequately assessed for malnutrition and whether identified patients had been referred to or received specialist nutritional assessment and support in a prompt manner.

**Methods** A prospective audit was performed on 77 acute medical admissions. Data was collected during the first 48 h of the patients' stay and was compared to the current recommendations highlighted in the NICE Clinical Guideline 32 – 'Nutrition