the Western General Hospital for colonoscopy and flexible sigmoidoscopy during the two periods were included. Cost effective analysis was also undertaken.

**Results** 1418 Colonoscopies and flexible sigmoidoscopies were carried out during period 1 and 1234 were carried out during period 2. 454 (32%) of the colonoscopies were carried out using Moviprep in period 1 and 973 (79%) in period 2. Poor quality preparation was significantly more common with Picolax preparation when compared to Moviprep in both period 1: 12 vs. 7% (p = 0.0037) and period 2: 13% vs. 5% (p < 0.0001). Repeat endoscopic procedures and completion imaging due to poor preparation fell from 44 (3.1%) in period 1 to 21 (1.7%) (p = 0.03) in period 2 following the change in default preparation to Moviprep. The estimated annual savings on repeat procedures and completion imaging across NHS Lothian of £89 000 offset the increased cost of Moviprep (£8.60 per patient vs. £3.65 for Picolax) of £23 265 annually.

**Conclusion** Changing to Moviprep as the default preparation for colonoscopy in NHS Lothian has resulted in significantly better quality bowel preparation. Furthermore fewer repeat procedures have been required resulting in more efficient use of scarce capacity and cost savings.

**REFERENCE**

1 http://www.nrls.npsa.nhs.uk/resources/?entryid45=59869

Disclosure of Interest None Declared.

**PHT-029 LIFESTYLE SCREENING AND BRIEF INTERVENTIONS IN A GASTROENTEROLOGY CLINIC**

1 Davies, A Kings, M Con福德-Hill, C Southwell, S Prabakaran, T Haldane, M Vardy, T Ahmad, Y Mehairi, D Aldaïs*, M Health, Mental Health Partnership, Worcestershire, UK; 2 General Medicine, Worcestershire Acute Hospitals NHS Trust, Worcester, UK; 3 University of Hull, Hull, UK

**Introduction** Worcestershire Acute Hospitals NHS Trust currently have an Alcohol Liaison Nurse (ALN) Service. In response to NICE and Making Every Contact Count we wanted to implement a lifestyle screening tool within the out patients clinic, and be able to offer signposting and an opportunistic Brief Intervention (Bl) service.

**Methods** Patients aged over 16 years attending a busy gastroenterology out-patients clinic were asked to complete a ‘lifestyle’ screening tool using the AUDIT-C (Babor 2001) to assess alcohol use and smoking status.

Individuals who were AUDIT-C positive (>5) were referred by the consultant to the Alcohol Liaison Nurse (ALN) for further assessment and Brief Intervention.

**Results** 448 patients attended the clinic. 60% (n = 269) were asked to complete the tool (2 refused).

32 (12%) individuals were identified as smokers. 13 males with a median age of 56 and 19 females with a median age of 49. 18 accepted an advice card.

82 (31%) AUDIT-C >5. 46 males with a median age of 53 and 36 females with a median age of 51. 27 accepted referral to ALN (3 unable to contact).

The highest reported motivating factors for change were improved physical and mental health, followed by better finances and weight loss. 75% of the sub-group receiving Brief Intervention could not identify any costs of change. The sub-group also scored high in relation to readiness to change and confidence to change following the Bl. Extended Bl reported reduced AUDIT-C scores and reduced drinking days/unit consumption.

**Conclusion** The results suggests that lifestyle screening is a achievable and acceptable in a busy gastroenterology clinic. A significant proportion of patients attending a gastroenterology clinic are likely to be using alcohol at harmful levels or smoking and are therefore likely to benefit from opportunistic Bl or signposting to smoking cessation services.

**REFERENCES**


Disclosure of Interest None Declared.

**PHT-030 CLINIC OUTCOMES FOR UNSELECTED PATIENTS REVIEWED BY DOCTORS AND ADVANCED NURSE CLINICIANS – IS THERE ANY DIFFERENCE?**

D McClements*, J Mclindon, R Chandy, S Priestley, M Fox, V Theis, J Dobson, A Bassi

Gastroenterology, St Helens and Knowsley NHS Trust, St Helens, UK

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**Introduction** There is a well-established role of specialist nurses in on-going management of chronic diseases in specialist clinics. With the reduction in junior doctor hours, advanced nurse clinicians (ANC) are taking on increasing complex medical roles. We aimed to evaluate the effectiveness of ANC in managing unselected new patients (NP) in the general gastroenterology clinic in a district general hospital.

**Methods** Analysis was done on 76 consecutive NP seen in the gastroenterology clinic over one week which then generated a further 66 follow appointments over an 18 month follow up period. We compared the direct service costs, diagnosis, outcome and discharge rates for each clinician grade. IBD patients requiring regular follow were excluded from the analysis. Cost analysis was performed using current NHS tariffs for the investigations performed.

**Results** Forty new patients (53%) were seen by an ANC, 26 (34%) by a consultant gastroenterologist and 10% (13%) by a middle-grade doctor (MG) at the first appointment. Forty referrals were on the ‘suspected cancer’ pathway, of these 68% were seen by ANC, 13% by a consultant 19% and by MG. Of the 36 non-urgent referrals – 36% were seen by ANC, 55% by a consultant and 9% by MG. The mean number of follow up appointments generated was 1.9 (ANC), 1.8 (consultant) and 2.2 (MG). ANC’s ultimately discharged 30 patients (39%), consultants 23 (30%), MG’s 7 (9%). Sixteen patients (21%) required long-term follow-up or did not attend. Consultants requested 16 investigations on new patients (0.62 tests/patient) costing £161 per patient, MG 15 investigations (1.5 tests/patients) costing £337/patient and ANC’s 50 investigations (1.25 tests/patient) costing £331/patient. Only 1 patient was referred back to clinic having been discharged and this was for a new and unrelated problem.

**Conclusion** In our hospital, nurse led and doctor led outpatient care was of equivalent effectiveness with no differences in
follow-up appointments generated or discharge rates from clinic. During the study period, nurse led care resulted in increased resource use compared with consultant led care – but could be partly explained by the greater proportion of patient seen in the ‘suspected cancer’ pathway. No adverse outcomes or missed diagnoses were observed over an 18 month follow up period. Our study would support the role of specialist nursing managing unselected patients in gastroenterology clinics.

Disclosure of Interest None Declared.

**PTh-031** AN INCREASING DEMAND FOR ENHANCED SEDATION ENDOSCOPY: A SINGLE CENTRE EXPERIENCE

'D Josh*, 1MA Austin, 2TB Bate, 3SA Cairns. 1Digestive Disease Centre, Brighton and Sussex University Hospital, Brighton; 2Department of Anaesthesia, Brighton and Sussex University Hospital, Brighton, UK

10.1136/gutjnl-2014-307263.477

Introduction The demand for enhanced sedation endoscopy (ESE) appears to be increasing due to increasingly challenging diagnostic and therapeutic procedures. BSG Working Party guidance were issued in 2011. Our aim is to describe a single centre experience and highlight the importance of providing such a service.

Methods Retrospective review of all patients undergoing elective ESE at Brighton and Sussex University Hospital (BSUH) from March 2012 to March 2013. Cases were performed in the endoscopy department and in a day surgery theatre. Patients were identified using the Unisoft endoscopy program and day theatre list records. Patient records were reviewed in addition to endoscopy reports. Data collection included patient demographics, indication for procedure, procedure length, success of procedure if previously failed and complications. Data presented as median with range.

Results A total of 89 procedures (OGD x 25 (28%), colonoscopy x 28 (31%), flexible sigmoidoscopy x 2 (2%), ERCP x 24 (27%), OGD/colonoscopy x 10 (9%)) in 79 patients were performed. Median age 53 years (22–75 years), weight 77.5kg (52–126 kg), BMI 26 (22–48), female 60%, ASA 2 (1–4). Indications for ESE included a previously poorly tolerated procedure (38%, n = 34), co-morbidities (24%, n = 21), patient choice (20%, n = 18), previously failed procedure (9%, n = 10) and likely long procedure (7%, n = 6). 80 patients received a combination of propofol/ fentanyl sedation whilst 9 patients required a full general anaesthetic. ESE was delivered by a designated anaesthetist. Median duration of procedure was 35 min (10–65 min). There were no endoscopic related complications. 1 patient developed hypotension requiring intravenous fluids and was admitted for observations overnight and 1 patient developed bronchospasm post extubation requiring intravenous steroid and nebulisers but did not require admission. The use of ESE resulted in the successful completion of all endoscopic procedures.

Conclusion Review of our referrals demonstrates an increasing demand of ESE. Our service initially began as an ad hoc list but now is weekly. ESE appears to be a safe, time efficient and reduces the requirement for repeat procedures.

**REFERENCE**

1 Guidance for th, UKe use of propofol sedation for adult patients undergoing ERCP and other complex upper GI endoscopy procedures, April 2011. NCQA and BSG working party.

Disclosure of Interest None Declared.

**PTh-032** GUT HORMONE SCREENING FOR GASTROENTEROPANCREATIC NEUROENDOCRINE TUMOURS – A QUALITY IMPROVEMENT PROJECT

1D Mansour*, 2J Lee. Gastroenterology, Gateshead Queen Elizabeth Hospital, Newcastle Upon Tyne, UK; 2Gastroenterology, Northumbria Healthcare Trust, North Tyneside, UK

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Introduction BSG guidelines advise that, in patients presenting with symptoms suspicious of gastroenteropancreatic neuroendocrine tumour (NET), baseline gut hormone (GH) tests should include Chromogranin A (CgA) and urinary 5HIAA. Other specific biochemistry should be requested depending on the syndrome suspected. We reviewed the use of gut hormone screening in a North East England Trust and examined the association between positive results and NET diagnosis.

Methods We reviewed all GH screens requested between July 2012 and June 2013. The following data were collected: specialty of requesting physician, indication, results and clinical outcome. We compared results of GH screens (CgA and then other GHs) with the diagnosis of NET to calculate specificity. Finally, we looked at all NET diagnosed in the trust over the same period, reviewing GH levels in those tested following diagnosis, in order to calculate sensitivity. Financial implications of different GH testing strategies were assessed using these results.

Results Of a total 51 requests for gut hormone screens, 21 were made by gastroenterologists and 8 by surgeons. 19 requests in total were made for investigation of diarrhoea, 12 for upper GI symptoms/peptic ulcers, 5 following positive histology or lesions on imaging and 15 for other symptoms. A total of 459 GH were tested at a cost of £315 per patient. 32/51 patients had normal CgA levels, none of which went on to be diagnosed with NET. 19 had a raised CgA of which 2 were already known to have NET but no new NET were found (specificity 65.31%). Patients with diarrhea had a particularly high false positive rate (7/19 = 36.8%). Of 18 patients newly diagnosed with NETs in the trust, 5 had GHs tested (all following diagnosis)-3/5 had raised CgA (cost £44 per patient),a sensitivity of 60% (this increased to 80% when combined with u5HIAA testing). Measuring other gut hormones only marginally increased sensitivity but greatly reduced specificity of the screening.

Conclusion Gut hormone screening was not being performed in line with BSG recommendations in our Trust, leading to excessive numbers of tests being performed with low sensitivity and specificity. We worked with the trust biochemistry department to clarify the indications for GH testing and rationalise the screening test performed. We now offer an ‘endocrine diarrhoea screen’ of CgA and u5HIAA. Other hormones are measured only if a specific syndrome is suspected/in patients with known history/family history of NET, representing a cost saving of £271 per patient. It is envisaged that this change in practice will save the trust at least £12,000 per annum whilst improving clinicians‘ decision making around testing for NET.

Disclosure of Interest None Declared.

**PTh-033** A SPECIALIST IRON DEFIENCY ANAEMIA CLINIC SIGNIFICANTLY REDUCES THE NEED FOR SECONDARY CARE FOLLOW UP

1ET Taylor*, 2JC Campbell, 3MD Donnelly, 4J Hebdon. Gastroenterology, Sheffield Teaching Hospitals, Sheffield, UK

10.1136/gutjnl-2014-307263.479

Introduction: Gastroenterology clinics are often used as a secondary care follow up for patients presenting with symptoms suspicious of gastroenteropancreatic neuroendocrine tumour (NET), baseline gut hormone (GH) tests should include Chromogranin A (CgA) and urinary 5HIAA. Other specific biochemistry should be requested depending on the syndrome suspected. We reviewed the use of gut hormone screening in a North East England Trust and examined the association between positive results and NET diagnosis.

Methods We reviewed all GH screens requested between July 2012 and June 2013. The following data were collected: specialty of requesting physician, indication, results and clinical outcome. We compared results of GH screens (CgA and then other GHs) with the diagnosis of NET to calculate specificity. Finally, we looked at all NET diagnosed in the trust over the same period, reviewing GH levels in those tested following diagnosis, in order to calculate sensitivity. Financial implications of different GH testing strategies were assessed using these results.

Results Of a total 51 requests for gut hormone screens, 21 were made by gastroenterologists and 8 by surgeons. 19 requests in total were made for investigation of diarrhoea, 12 for upper GI symptoms/peptic ulcers, 5 following positive histology or lesions on imaging and 15 for other symptoms. A total of 459 GH were tested at a cost of £315 per patient. 32/51 patients had normal CgA levels, none of which went on to be diagnosed with NET. 19 had a raised CgA of which 2 were already known to have NET but no new NET were found (specificity 65.31%). Patients with diarrhea had a particularly high false positive rate (7/19 = 36.8%). Of 18 patients newly diagnosed with NETs in the trust, 5 had GHs tested (all following diagnosis)-3/5 had raised CgA (cost £44 per patient),a sensitivity of 60% (this increased to 80% when combined with u5HIAA testing). Measuring other gut hormones only marginally increased sensitivity but greatly reduced specificity of the screening.

Conclusion Gut hormone screening was not being performed in line with BSG recommendations in our Trust, leading to excessive numbers of tests being performed with low sensitivity and specificity. We worked with the trust biochemistry department to clarify the indications for GH testing and rationalise the screening test performed. We now offer an ‘endocrine diarrhoea screen’ of CgA and u5HIAA. Other hormones are measured only if a specific syndrome is suspected/in patients with known history/family history of NET, representing a cost saving of £271 per patient. It is envisaged that this change in practice will save the trust at least £12,000 per annum whilst improving clinicians‘ decision making around testing for NET.

Disclosure of Interest None Declared.