Introduction BSG guidelines provide clear recommendations for the investigation and management of iron deficiency anaemia (IDA). The algorithm lends itself to a 'one stop' new patient clinic in secondary care with further follow-up in primary care. We set up a dedicated IDA clinic aiming to streamline patients' management and reduce unnecessary follow-up visits.
Methods A 'one stop' IDA clinic was set up and run by a single gastroenterologist from November 2013. Data was collected prospectively for the first 60 patients referred with IDA (Group A). Patients without confirmed IDA (10, [17%]) were analysed separately. A second group of proven IDA referrals seen in unselected gastroenterology clinics in 2011 was identified (Group B). Rates of clinic follow up were recorded and the two groups compared. Additional data collected included demographics, haemoglobin, MCV, ferritin and other iron indices (Fe/TIBC) as well as radiology and endoscopy reports. Iron deficiency was defined as isolated microcytosis and/or low ferritin.
Results Fifty patients fulfilled diagnostic criteria for IDA in group A (35 female, median age 69.0, range 35–91). Group B comprised 50 IDA patients (28 female, median age 72.0, range 38–83). All patients in Group A were seen by a single, UKconsultant compared to 80% seen by consultants in Group B.

Four patients were diagnosed with colorectal cancers in group A. Two patients were diagnosed with oesophago-gastric tumours and 4 with colorectal cancers in group B. One new diagnosis of coeliac disease was made in each group. Group A contained five females with gynaecological pathology responsible for IDA (1 advanced cervical cancer and 4 menorrhagia).

Despite confirmation of IDA with a low ferritin, 11 (22%) in Group A and 6 (12%) in Group B had undergone additional serum iron/TIBC measurements before referral. Only 3/17 (18%) iron studies were congruent with the ferritin result.

Significantly more patients in Group A (94%) were discharged back to primary care after their initial consultation and investigations compared to Group B (26%, $p < 0.0001$).
Conclusion A specialist IDA clinic leads to appropriate discharge to primary care virtually eliminating secondary care follow up. Clinical assessment allows identification of a significant proportion of non-IDA referrals requiring alternative management. Measurement of serum iron/TIBC should be discouraged.
Disclosure of Interest None Declared.

PTH-034 THE SAFE AND EFFECTIVE TREATMENT OF IRON DEFICIENCY WITH IRON ISOMALTOSIDE 1000 - CLINICAL EXPERIENCE FROM A UK GASTROENTEROLOGY UNIT

[1]E Williams*, [1]L Craven, [1]S Surgenor, [2]U Bapat, [3]C Strom, [1]J Snook. *[1]Poole Hospital Foundation Trust, Poole, UK; [2]Pharmacosmos, Thame, UK; [3]Pharmacosmos, Holbaek, Denmark*

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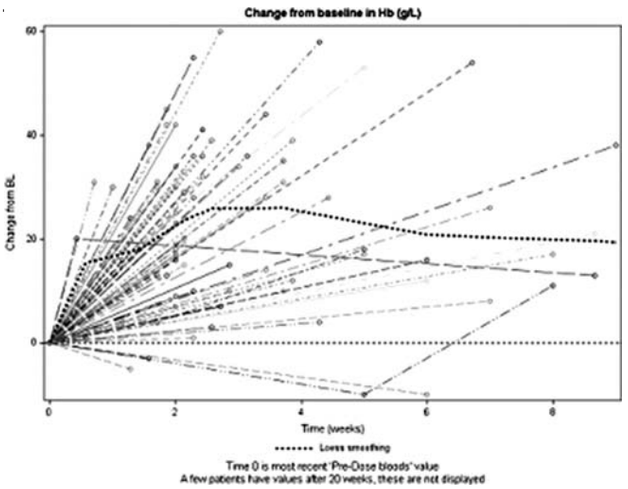
Introduction Parenteral iron has been used increasingly over the last decade to treat specific patient groups with iron deficiency (ID) anaemia. There is, however, limited evidence of safety and efficacy in all patients with ID, particularly those with underlying malignancy or inflammation.
Methods Data from all outpatients receiving iv iron isomaltoside (Monofer) for confirmed ID between 1st April and 31st December 2012 at our UK District General Hospital was analysed, regardless of underlying diagnosis or comorbidity. Patients received their infusions under the care of Gastroenterology on our Medical Investigations Unit, a 7-day nurse led unit that works extended hours and is located within the main hospital.



Abstract PTH-034 Figure 1

ID was defined by ferritin <24 mcg/l, transferrin saturation index (TSAT) <15% or a blood film compatible with ID. Anaemia was defined as a low haemoglobin concentration (Hb) (men <130 g/l, women <115 g/l). Data was collected for each patients first treatment within the study period only, albeit 1 or 2 infusions. The dose of parenteral iron was at the discretion of the referring Consultant. All patients had post infusion bloods, 75 (88%) within 4 weeks. Data on the cause of ID and significant comorbidity was collected.
Results 85 patients received monofer infusions for confirmed ID over the study period, with 80 of these having ID anaemia. Referrals were from a range of medical, surgical and oncological specialities. 55 patients (65%) were female and the age range was 18–92 years (median 73 years). Baseline bloods (median and interquartile range (IQR)) were Hb 90 g/l (80–99), Mean Cell Volume 81 fl (72–88), Mean Cell Haemoglobin 24.8 pg (22.2–28.0), ferritin 15mcg (9–24) and TSAT 9% (5–15).

Most patients had extensive comorbidity; 29(34%) had active malignancy and 44(77%) of those without malignancy had active inflammation. The median iron dose was 14.6 mg/kg (IQR 11.2–17.5). No significant adverse reactions occurred and all patients received the full infusion.

Post infusion bloods demonstrated a median increase in Hb of 23 g/l (Figure 1) with 52% having a Hb increase of >20 g/l. The Hb rise was significantly higher in individuals with a lower baseline Hb; regression slope of baseline against change in Hb = -5.9 Hb, $p < 0.0001$.
Conclusion Treatment of ID anaemia with parenteral iron is safe and effective in all patients including those with cancer or active inflammation. A rapid rise in Hb within 4 weeks is seen in many patients particularly where the baseline Hb is low.
Disclosure of Interest None Declared.

PTH-035 PULMONARY MISPLACEMENT OF NASOGASTRIC TUBES: A 2 YEAR AUDIT OF SERVICE DELIVERY, FEEDBACK INTERVENTION AND PATIENT OUTCOME

[1]F Mansour*, [1]M Virta, [2]P Neild, [3]T Marshall. *[1]St George's Medical School, St George's University of London, London, UK; [2]Gastroenterology, St George's NHS Trust, London, UK; [3]Nutrition, St George's NHS Trust, London, UK*

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Introduction Although nasogastric feeding will continue to be the preferred method of assisted nutrition, after oral intake, better