Abstract PTH-039 Table 1 Summary of complications

	Before protocol	After protocol				
	Number (%)	NSAID (102)	no NSAID (62)	PD stent (17)	no PD stent (163)	Number (%)
Pancreatitis	2/67 (3)	5	0	1	5	6/180 (3)
Perforation	0/67 (0)	1	0	0	3	3/180 (1.5)
Bleeding	2/67 (3)	2	0	0	3	3/180 (1.5)
Admission	7/67 (10)	10	1	1	10	11/180 (6)

224 amylase tests were performed on 139 patients. 27/139 patients had abnormal amylase (>1.5x upper limit normal (ULN) at 2–4 h or 3–5x ULN at 4–6 h). 14 were asymptomatic, 3 patients were admitted. Remainder with mildly abnormal amylase were managed without admission after clinical assessment.

There were total 8 cases of pancreatitis (3.2%), all associated with significantly raised amylase, apart from one (inpatient) case with a late rise at 48 h. Pre-protocol, 1 patient developed pancreatitis after discharge from day case.

NSAID use rose from 0 to 57% (14% contraindications), with no increased bleeding associated. PD stent insertion rose but remained infrequent, limited by technical feasibility. Pancreatitis rates did not significantly differ with prophylactic measures.

Conclusion This audit demonstrated the real-life practice of ESGE guidelines to assess for and reduce ERCP-related complications. Amylase measurement was feasible – raised levels correlated with PEP but 1 case had normal early amylase. The few admissions with asymptomatic raised amylase is offset by avoiding emergency admission with PEP. In this small study NSAID and PD stent did not improve complication rates and remain under-utilised, but likely will increase as experience grows.

REFERENCE

1 Dumonceau JM *et al*. European Society of Gastrointestinal Endoscopy (ESGE) guideline: prophylaxis of post-ERCP pancreatitis. *Endsocopy* 2010;42:503-515

Disclosure of Interest None Declared.

PTH-040 USING NICE CRITERIA TO ASSESS THE MANAGEMENT OF ACUTE UPPER GI BLEEDS DURING WEEKENDS – THE EXPERIENCE OF A DISTRICT GENERAL HOSPITAL

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Introduction The management of acute upper GI bleeds (AUGIB) comes under greatest stress at weekends; this is a topical concern given the national drive towards a 7 day working week. We previously described the development of a centralised cross-county out of hours endoscopy service.[1] We aim to critically appraise this service against NICE guidelines (CG141) and quality standards (QS38) for the management of AUGIB.

Methods Our computer-based endoscopy database was retrospectively analysed to identify patients undergoing gastroscopy (OGD) for AUGIB during the weekend in 2012. Full demographic information and OGD reports were identified in all 95 cases; complete patient records were located for 66 (69%) patients.

Results The average patient age was 71. 66% were new episodes of AUGIB: the rest had AUGIB during admission with different pathology. 11% (10) of patients did not survive their admission. 81% (76/95) had significant diagnoses on OGD. Of note, 38% (36) of patients had peptic ulcer disease, 8% (7) had cancer and 5% (4) had varices.

While 86% (57/66) of patients received a pre-endoscopy Rockall score, 11% had full Rockall scores, and only 3% had a Blatchford score documented. 55% (37) of patients underwent transfusion; half were overtransfused to a Hb >10 g/dL. Correction of coagulopathy was adequate in 4 of 6 patients. Platelet and recombinant factor VII use was in keeping with NICE guidance. 36% of patients inappropriately received intravenous PPI prior to OGD. Only 1 of 5 patients with suspected variceal bleeding received antibiotics and terlipressin at presentation.

6% (4/66) of patients remained haemodynamically unstable despite resuscitation – all had OGDs within four hours of admission. 88 and 95% of patients underwent OGDs within 24 and 48 h of admission respectively. The main reasons for delays were lags in submitting OGD request forms and inadequate fasting, rather than a lack of endoscopy capacity. All patients received appropriate endoscopic therapy modalities, and timely repeat OGDs or surgical intervention when warranted. All patients on aspirin for secondary prevention of vascular events were recommenced on aspirin when haemostasis was safely achieved.

Conclusion The trust provides a comprehensive out of hours endoscopy service, particularly for emergency cases with persisting haemodynamic instability. There remains scope for further improvement in pre- and post-endoscopy care. This exercise highlights the use of NICE-generated standards in guiding service development, and can be replicated in most district general hospitals.

REFERENCE

1 ShokouhiBN *et al*. The setting up and running of a cross-county out-of-hours gastrointestinal bleed service: a possible blueprint for the future. *Frontline Gastroenterol* 2013;4:3 227–231

Disclosure of Interest None Declared.

PTH-041 A HIGH QUALITY TRANSIENT ELASTOGRAPHY SERVICE CAN SUCCESSFULLY BE DELIVERED BY HEALTHCARE ASSISTANTS

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Introduction Surrogate assessment of liver fibrosis by means of liver stiffness measurement (LSM) by transient elastography is well validated in different cohorts of patients with liver disease and is now a part of routine hepatological practice. There is an increasing demand for LSM in view of its role in managing patients with dermatological or haematological conditions who are on potentially fibrogenic therapy. Referrals for LSM in our unit have increased significantly over the last 12 months. Traditionally, specialist liver nurses have been trained to deliver this service. However, LSM by transient elastography is an easily transferable skill and therefore in a bid to reduce waiting times and make the service as cost effective as possible, we trained

healthcare assistants (HCA) to perform LSMs. The aim of this review was to assess the impact of this change on the quality of LSM as measured by success rate and failed scans.
Methods A transient elastography service delivered by trained specialist liver nurses was set up in our hospital in May 2010. In July 2013, 3 HCAs were trained to carry out LSM using a Fibroscan®. The HCAs were initially trained by the manufacturers of the Fibroscan® unit (Echosens Europe) and then underwent a period of formally observed training with formative and summative work place based assessments. After competency was ascertained, the HCAs were independently allowed to carry out LSMs. A retrospective review of all LSM reports from January 2013 to December 2013 was carried out and success rate of the tests were recorded. Any repeat requests due to failure were also recorded.
Results A total of 876 LSM were performed during the review period. 542 LSMs were performed by trained nurses and 334 by trained HCAs. There was no statistically significant difference in the mean success rate between nurses (96% SD 11.9%) and HCAs (96.4% SD 11.7%) ($p = 0.699$, 2 sample T Test) nor the proportion of LSMs with 100% success rates between the two groups (78.4 vs. 82.3% $p = 0.151$, Fisher's exact test). Furthermore, there were no statistical differences in any central measure of the observed interquartile ranges of the reported LSM between the 2 groups ($p = 0.255$). No LSM was repeated when performed by HCA for reasons of failure.
Conclusion LSM using a Fibroscan® can be accurately performed by appropriately trained HCAs. The introduction of this change in practice has allowed a reduction in waiting time for LSM to within 2 weeks without affecting the quality of the service and allowed a more efficient use of resources. A high quality transient elastography service can be delivered by HCAs.
Disclosure of Interest None Declared.

PTH-042 CLARIFYING THE REFERRAL PATHWAYS FOR PATIENTS DIAGNOSED WITH GASTROINTESTINAL CANCER: IS THE 'RED-FLAG' PATHWAY WORKING?

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Introduction The Cancer Access or 'Red-Flag' referral pathway was introduced to facilitate appropriate referral between primary and secondary care for cases of suspected cancer. Despite this, many cases of upper and lower gastrointestinal (GI) cancer are diagnosed through 'routine' referral grading, emergency presentations, and in the case of colorectal cancers, the bowel cancer screening (BCS) programme. The purpose of this study was to assess the original referral pathway for patients diagnosed with gastrointestinal cancer within our Health Trust and the effects, if any, on patient outcomes.
Methods We looked at a random sample of clinical notes of 107 patients diagnosed with a GI cancer between April 2011 and December 2012 within our trust (56 patients with lower and 51 patients with upper GI cancer) to determine referral source and grade, whether red-flag criteria were positive, staging and outcomes, whether curative or palliative.
Results 58 patients (54%) diagnosed with upper or lower GI cancer had been referred to the Trust via GP (with 22% seen initially at clinic and 32% at direct access endoscopy), 5 patients (5%) had been referred to clinic by another physician, 28 patients (26%) attended through casualty, 10 patients were diagnosed through the BCS programme (9%), 5 oesophageal cancers (5%) through Barrett's surveillance, and 1 colorectal cancer (1%) through polyp surveillance. All 27 lower GI cancer patients initially referred by their GP had 'red-flag' symptoms, but only 12 (44%) were referred with an initial 'red-flag' grade; similarly, all 31 upper GI cancer patients initially referred by GP had 'red-flag' symptoms, but only 15 patients (48%) were initially referred as 'red-flag'. Of the 51 upper GI cancer patients, 20 underwent curative treatment; 11 such patients were referred from GP (5 of which were originally referred as 'red-flag'), 3 from another physician, 5 from Barrett's surveillance and 1 casualty self-presenter. Of the 56 lower GI cancer patients, 33 underwent curative treatment – 17 referred from GP (only 7 originally referred as 'red-flag'), 6 casualty self-presenters, and all 10 BCS patients (all Dukes' A-B). Of the 54 palliative cases of either upper or lower GI cancer, only 15 of the 30 patients referred by their GP were referred through the 'red-flag' pathway.
Conclusion All patients diagnosed with a GI cancer that were originally referred from primary care had evidence to satisfy 'red-flag' referral, although less than half of these were referred through the 'red-flag' pathway. This study highlights the need for ongoing education and reinforcement of the 'red-flag' referral criteria.
Disclosure of Interest None Declared.

PTH-043 OUR EXPERIENCE OF A PHARMACIST LED IMMUNOMODULATOR (IMD) CLINIC: A NOVEL SERVICE IN A DISTRICT GENERAL HOSPITAL

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Introduction Increasing numbers of patients are being treated with immunomodulators (IMD) for inflammatory bowel disease (IBD) and autoimmune hepatitis (AIH). This needs intensive monitoring and impacts by increasing clinic waiting times. After approval from the Quality and Safety Board of the Trust, a pharmacist led IMD clinic was established in 2012 to manage patients initiated on IMD for initial monitoring and dose titration with a view to reduced clinic visits.
Methods Patients were referred to the pharmacist led clinic by the gastroenterologists and IBD nurse specialist for commencing and monitoring of IMD after initial counselling. Screening blood tests including the TPMT assay were checked prior to commencing the IMD as per agreed protocol. The pharmacist issued prescriptions and patients were given blood forms for weekly tests for the initial two months, fortnightly for the next two months and three monthly thereafter. Results were monitored by the pharmacist and patients were offered a choice of telephone or email consultations with the pharmacist for subsequent appointments. The pharmacist had easy access to advice from the clinician in the event of adverse effects. After initial stabilisation patients were referred back to the GP or the referring clinician for follow up.
Results 81 patients were referred to the pharmacist led IMD clinic between October 2012–2013 [(50F); Median age 44 (range 19–76)]. Indications for treatment were IBD (n = 73) [ulcerative colitis (n = 33), Crohn's (n = 40)] and AIH (n = 8). Twenty seven patients (33.3%) experienced side effects between weeks 2 to 6 of initiation of treatment. These were nausea or vomiting 16% (n = 13), skin rash 1% (n = 1), fatigue 1% (n = 1),myalgia 1% (n = 1), intolerance 1% (n = 1) and stomach cramps 1% (n = 1). Abnormal blood tests were noted in 23.4% (n = 19) patients. These