

Abstract PTH-128 Table 1 Anatomical and histological distribution of SBC

	Duodenum	Jejunum	Ileum	Unknown	Total
Adenocarcinoma	21	9	4	3	37
Neuroendocrine	3	1	6	1	11
Sarcoma	1	0	0	1	2
Unknown	75	12	20	48	155
Total (n)	100	22	30	53	205

retrospectively reviewed medical records collecting data on patient demographics, environmental and medical risk factors, family history, natural disease progression and immunohistochemical analysis (IHC).

Results The registry identified 205 SBC patients, 58% male and 42% female, who were diagnosed at a mean age of 63 years. Patients presented with abdominal pain (23.3%, n = 60), altered bowel habit (16.7%), weight loss (15.0%), bowel obstruction (15.0%) jaundice (13.3%), anaemia (10.0%) and other (6.6%). Investigations included CT (85.7%, n = 35), MR (8.6%) and barium (11.4%) imaging; gastroscopy (37.1%) that detected 8 of 9 duodenal SBCs and were reported normal in 2 jejunal and 2 ileal SBCs, DBE (2.9%) and ERCP (2.9%) that detected 1 duodenal SBC each; emergency (8.6%) and staging laparotomy (8.6%). SBC anatomical and histological distributions are described in Table 1. Patients were diagnosed at disease stage I (11.4%, n = 35), II (22.9%), III (20.0%) and IV (45.7%). Treatment included curative surgery (66%, n = 38; 12 resections, 7 bypasses and 6 Whipple procedures and adjuvant chemotherapy (AC) in 20%) with a 60% success rate and recurrence in 16.7% within a year; palliative surgery (18.4%; 6 bypasses and AC in 66.7%) and medical palliation (15.6%). Mortality rates at 1, 2, 5 and 10 years were 74.3%, 79.8%, 91.7% and 98.2% respectively (n = 109). Environmental factors included smoking (47%, n = 53) and drinking alcohol (51.1%, n = 45). Co-morbidities included peptic ulcer disease (8.4%, n = 72), coeliac disease (4.2%), Crohn's disease (1.4%) and ulcerative colitis (1.4%). Furthermore, 23.6% of patients (n = 89) had ≥ 1 other malignancies that were metachronous (83.3%), synchronous (12.5%) or both (4.2%). Family history included a 1st or 2nd degree relative with malignancy (28.2%, n = 39) or familial adenomatous polyposis (7.7%). IHC showed Lynch syndrome and adenomatous polyposis coli gene mutations in 42.1% (n = 19) and 40% (n = 10) respectively.

Conclusion Our understanding of SBC is limited by its insidious course, difficult assessment and rarity coupled with multiple histological subtypes. A more comprehensive understanding of SBC and its genetic predisposition may allow high-risk patient stratification to earlier identify and treat SBC thus improving its poor prognosis.

REFERENCE

- 1 Ross et al. *British Journal of Cancer* 1991;63:143–145

Disclosure of Interest None Declared.

PTH-129 A RETROSPECTIVE AUDIT OF PEG INDICATIONS AND COMPLICATIONS AT A DISTRICT GENERAL HOSPITAL FOLLOWING THE INTRODUCTION OF A MULTI-DISCIPLINARY NUTRITION TEAM

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Introduction Percutaneous endoscopic gastrostomy (PEG) is the preferred method for inserting feeding gastrostomy tubes. The national confidential enquiry into PEG outcomes showed that patient selection was paramount for improving associated mortality and morbidity rates [1]. We carried out a retrospective audit into the indications and complications associated with PEG insertion at West Suffolk Hospital, a district general hospital, during 2008–2009 and 2013. During this period a multidisciplinary nutrition team approach and PEG referral proforma were introduced.

Methods Retrospective audit data were collected during two periods, January 2008 to December 2009 and January to September 2013. The indication for PEG, documentation of antibiotic prophylaxis, the presence of a MDT review and complications post PEG insertion were audited.

Results 55 PEG placements occurred during the first audit cycle. 56% were inserted for dysphagia caused by cerebrovascular accident. Antibiotic prophylaxis were documented in 80% of cases. Seven patients did not have an MDT discussion during the admission. There were no immediate complications. Three patients died within 30 days of PEG insertion (two died of pneumonia and one from large bowel obstruction). There were 36 PEG insertions during the second audit cycle. 39% were inserted for dysphagia caused by CVA. Antibiotic prophylaxis were documented in 83% of cases. All patients had an MDT discussion. Two immediate complications were reported. There were no reported deaths 30 days post procedure.

Conclusion Following the introduction of a systematic MDT approach to PEG, there has been a reduction in 30 day mortality post-PEG insertion. When carefully monitored the use of PEG for long term enteral feeding can be used safely and successfully in a district general hospital.

REFERENCE

- 1 Simon D, Johnston Tony CK, Tham Marisa Mason, Death after PEG: results of the National Confidential Enquiry into Patient Outcome and Death. *Gastrointestinal Endoscopy* August 2008; 68(2):Pages 223–227, ISSN 0016–5107

Disclosure of Interest None Declared.

PTH-130 A COMPARISON OF THE NUTRITION SCREENING TOOL AND MALNUTRITION UNIVERSAL SCREENING TOOL ON REFERRAL RATES FOR DIETETIC ASSESSMENTS

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Introduction We aimed to compare the “Nutrition Screening Tool” (NST) and the “Malnutrition Universal Screening Tool” (MUST) on referral rates for dietetic assessments in in-patients in a Tertiary Neurology and Neurosurgery unit. Each tool generates a score above which dietetic assessment is recommended (a NST a score of 12 or more out of 22, a MUST score of 2 or more out of 5). The MUST score is considered the gold standard assessment method. The NST has been introduced in some centres with anecdotal reports of a reduction in referrals for dietetic assessment.

Methods In-patients at the National Hospital for Neurology and Neurosurgery were assessed for a one month period. The NST and MUST was completed on all available in-patients. A comparison of the number of referrals to dieticians was made using each assessment tool.