Results 136 patients were screened. There were 77 women and 59 men. The age range was 18–89 years. The mean age was 52.4 years. For women the mean age was 49.7 years. For men the mean age was 56.0 years.

There was a highly significant difference in the numbers referred to the dieticians. Using the NST scores, 3 out of 136 patients scored 12 or more (3 referrals (2%)). Using the MUST scores, 20 out of 136 patients scored 2 or more (20 referrals, (15%)) (P < 0.0001).

The NST identified that 12 patients scored 8 or more. 7 of these had a MUST score of 2 or more. This means 58% of patients who score 8 or more using the NST would have been referred using the MUST. The NST identified that 13 patients scored 7 or more. 8 of these had a MUST score of 2 or more. This means 62% of patients who score 7 or more using the NST would have been referred using the MUST.

The NST identified that 14 patients scored 6 or more. 9 of these had a MUST score of 2 or more. This means 64% of patients who score 6 or more using the NST would have been referred using the MUST.

Conclusion Using the NST results in a significantly lower number of referrals to dietitians compared to when nutritional assessment is made using the MUST score. This may be due to the NST score required for referral being too high. Therefore the NST needs to be revalidated using a lower referral score, possibly between 6 and 8. Further studies are required in order to ascertain the specific NST score appropriate for referral.

Disclosure of Interest None Declared.

Abstract PTH-131

<table>
<thead>
<tr>
<th>Gastropexy</th>
<th>PEG</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years)</td>
<td>63.2</td>
<td>66.9</td>
</tr>
<tr>
<td>Mean Midazolam (mg)</td>
<td>3.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Mean Pethidine (mg)</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>7-day mortality (%)</td>
<td>3.5</td>
<td>6.4</td>
</tr>
<tr>
<td>28-day mortality (%)</td>
<td>14</td>
<td>18.3</td>
</tr>
</tbody>
</table>

Eighty three percent of gastropexy and 97% of PEG’s were done under conscious sedation. The remaining gastropexy insertions were done under GA as a part of another surgical procedure. Technical success was achieved in 98 and 100% for gastropexy and PEG respectively. Minor gastric fluid leak in 1 patient in gastropexy group and mouth bleed in 1 patient in PEG group was noted. No procedure related deaths were noted in either of the groups.

Conclusion In the context of risk from tumour seeding and mucosal trauma to narrowed upper GI tract, endoscopic gastroscopy procedure seems non-inferior to PEG’s. It seems safe and can be done with high technical success rate. Perhaps, it may be an alternative to PEG in patients with inherently difficult upper GI tract and major illness like cancers.

Disclosure of Interest None Declared.

Abstract PTH-132

Introduction Nottinghham University Hospitals (NUH) NHS Trust serves as a tertiary centre for Gastroenterology, Stroke, Neurosurgery and Oncology. Our current practice for vention referrals differs for PEG and RIG. PEG requests are forwarded to the Nutrition Team for vetting. RIG referrals are sent directly to Radiology for vention. Our Specialist Nutrition nurses provide a robust assessment including clinical assessment, dietician and speech and language therapy review. Complex cases are discussed with a Gastroenterologist. Pre-procedure review of RIG patients may be undertaken by any physician.

Methods We retrospectively reviewed all PEG and RIG referrals from 2012. The nutrition records, case notes and electronic records were reviewed. We collected data on referring specialty, indication and 30-day complication and mortality rates. Data was collated onto a database for analysis.

Results 329 referrals were received; 148 for PEG and 181 for RIG. Of these, 76 (51.4%) were deemed appropriate for PEG and 168 (92.8%) for RIG. Reasons for refusal included patient fitness, meeting nutritional needs, suitable for alternative method of feeding or unsuitable for anatomical/technical reasons. Main service users were Stroke and Neurology, other medical specialties, Clinical Oncology, Neurosurgery and Ear, Nose and Throat.
Indications included intracranial events, head and neck cancers and dysphagia secondary to gastroenterological, neuromuscular or neurodegenerative conditions.

30-day complications: Stoma site infections; (15.8% for PEG and 19.6% for RIG), chest infections; (6.58% for PEG and 6.55% for RIG) and minor complications (including blocked or dislodged tube); (5.26% for PEG and 11.9% for RIG). Major complications were low (0% for PEG and 2.97% RIG - including perforation (0.60%), respiratory arrest (0.60%), desaturation (0.60%) and pneumoperitoneum (1.19%)). 30-day all-cause mortality was 6.58% (PEG) and 8.33% (RIG).

Conclusion Pre-screening PEG referrals identified more inappropriate cases than those referred for RIG. With the exception of chest infections, 30 day minor and major complications were lower in the PEG group, as was 30-day all-cause mortality. We hypothesise that the less rigorous screening process may be contributing to excess complication and mortality rates of RIG insertion. This may, or may not be unique to our Trust. RIG is usually the second line method of insertion, and we recognise that this patient group may have a poorer pre-morbid state. We recommend formal assessment of all gastrostomy referrals regardless of insertion technique. The Nutrition Team is currently looking towards pre-screening all gastrostomy referrals.

Disclosure of Interest None Declared.

### PTH-134 MALNUTRITION SCREENING IN HOSPITAL OUTPATIENTS

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Introduction NICE Guidelines (2006) advocate the screening of all new hospital outpatients in order to identify individuals at risk of malnutrition within the community. However, existing data in support of outpatient screening are limited. To establish the utility of screening in specific outpatient settings, data were collected from targeted clinics. Patterns of risk associated with age, gender, ethnicity and “new” or “follow up” outpatient status were determined.

Methods The Malnutrition Universal Screening Tool (MUST) was used to assess the nutritional status of all individuals attending outpatient appointments at eight clinics at St. Mary’s Hospital, Imperial College Healthcare NHS Trust. These were Gastroenterology, General Surgery, Geriatric Falls, Oncology, Chest and Allergy, Hypertension, Dermatology and Gynaecology/Urogynaecology. Appropriate action was taken as per guidelines for patients identified as ‘at-risk’.

Data were analysed using descriptive statistics, chi-square and logistic regression.

Results 585 outpatients were screened over a six week period (male 35.9%, n = 210/585; female 64.3%, n = 375/585; median age = 52, range 16–91 years; white ethnicity 57.7%, n = 338/585; non-white ethnicity 42.3%, n = 247/585). The overall prevalence of malnutrition risk was 12.1% (n = 71/585). There was a significantly higher risk of malnutrition in the young (16–24 years) and the elderly (≥ 75 years) (p = 0.04) and in individuals of white ethnicity (p = 0.0002). There was no difference in the prevalence of risk between new or follow up patients.

There was a predictably high yield in Gastroenterology, General Surgery, Oncology and Geriatric Falls clinics. Low prevalence of risk was found in Hypertension and Gynaecology/Urogynaecology clinics.

The Dermatology clinic yielded notable results with a 15.0% (n = 20/133) prevalence of risk. 8/12 of these patients were identified as medium risk (MUST score 1) due to a BMI of 18.5–20.0 kg/m²; 7/8 were female and of white ethnicity.

Conclusion There have been no published studies of larger cohorts in a hospital outpatient setting.