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 premorbid 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-133 ELECTRONIC PERSONAL HEALTH RECORDS FOR PATIENTS ON HOME PARENTERAL NUTRITION: A PATIENT SATISFACTION SURVEY

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Introduction The public demand for flexible access to health information and services is growing, encouraged by Intnet trends and policies promoting patient involvement. Patients Know Best® (PKB) is an electronic patient centred system providing a secure forum for patients to interact with healthcare teams. With increasing use of this system by our home parenteral nutrition patients we aimed to assess patient satisfaction with a survey.

Methods PKB was introduced to patients during routine clinic visits and verbal consent obtained. We recorded the frequency of use, total number of electronic discussions held and the number of additional carers (other healthcare staff or family members) involved in their personal health record. We distributed a 10 question survey to all users.

Results 119 patients (50 male, 69 female) were registered over a period of 18 months with a median age of 49 years (range 17–85 years, mean 48 years). A total of 5015 unique electronic conversations were recorded. These would usually have occurred via telephone. PKB has been used for 4 patients transitioning from paediatric to adult services and 2 patients from abroad. Other patients invited included 128 outside clinicians (eg local nutrition nurses and dietitians, transplant coordinators) and 29 carers. There were 58/119 (48.7%) responses including 1 incomplete dataset (61% female). 31/57 patients (54.4%) were over 50 years of age. 42/57 (73.7%) received parenteral nutrition and 13/57 (22.8%) fluids and electrolytes. 51/58 (87.9%) patients felt at least "somewhat confident" working online with their healthcare team and the same number felt that having access to the results was at least "somewhat helpful" – 32 (62.7%) of these responding "very/extremely helpful". 30/58 (51.7%) use PKB a few times a month, 4/58 (6.9%) a few times a week and the remainder less frequently. The more useful features of PKB included Discussions (ie contacting the St Mark's Nutrition team electronically) and Monitoring (ie test results). Patients use PKB to contact doctors/nutrition nurses more than dietitians/administrators.

Conclusion Our survey suggests that our patient cohort find this a useful facility to contact us and improve the management of their long-term conditions. Not all patients access PKB regularly and they only had a short period in which to respond to the survey. This may explain the 49% response rate in an otherwise motivated patient population. This is an emerging and effective way for patients to interact with their healthcare teams and we have not found it has increased our workload. The ability to communicate seamlessly between different healthcare professionals reduces the current difficulties which exist when transferring information between multiple care providers (eg HIFNET).

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 = 12/80) 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/m^2; 7/8 were female and of white ethnicity.

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

The prevalence of total malnutrition risk in this population, as determined by MUST, was lower at 12.1% compared to previously published smaller studies. 'At risk' groups were the young, the elderly and individuals of a white ethnic background.

Many patients 'triggered' with a MUST score of 1, BMI 18.5–20.0 kg/m^2, which is in fact within the normal range. This was particularly notable in a cohort of young women attending the Dermatology clinic.

The use of MUST in an outpatient setting requires further validation to ensure malnutrition risk is appropriately identified.

Disclosure of Interest None Declared.

PTH-135 OSTEOMYELITIS IN ADULT PATIENTS ON LONG-TERM PARENTERAL NUTRITION

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Introduction Osteomyelitis (OM) has rarely been reported in association with central venous catheter (CVC) use, but there are no reported data on the prevalence of OM in patients with intestinal failure (IF) with long term CVCs for parenteral nutrition (PN). We assessed period prevalence and characteristics of OM in adult patients on home PN.

Methods This was a retrospective study from a prospectively maintained database of patients referred to a national IF unit (IFU). Age, time on home PN, cultured organism (s) and OM site were recorded. Patients were divided into 2 groups: OM occurring in the context of acute (Type 2) IF (AIF) or chronic (Type 3) IF (CIF). Statistical analysis was Student's t-test.

Results 19 cases of OM occurred in 15 patients (6 male (40%)) between 2004–2013. There were 9 cases of OM in 9 patients with AIF, and 10 cases in 6 patients with CIF; the latter yielded a period prevalence for OM of 1.3% when compared to the 457 home PN (HPN) patients managed by the IFU over this period. There were no cases of OM in the preceding 9 years (1995–2004) at the IFU. Median (range) age at commencing PN was 66 (30–72) years in AIF compared to 64 (29–70) years in CIF and mean (95% CI) Charlson co-morbidity score was 3.7 (±2.5) in AIF compared to 2.2 (±0.9) in CIF. Patients with AIF had spent less time on PN before developing OM, compared to patients with CIF; despite this, the rate of CRBSIs was higher in the AIF than in the CIF group (see Table) as a result of patients with AIF contracting CRBSIs prior to specialised referral. Organisms and site of infection are shown in the table; identification of organism from the site of the OM successfully occurred in 3/9 (33%) cases in AIF and 3/10 (30%) cases in CIF, the remaining were identified via blood culture and aspiration of collections except one case where no organism was found, for which TB was suspected. All but one patient received at least 6 weeks antimicrobial chemotherapy; a further case required treatment for 3 months with antibiotics, 3 months with antifungals and 9 months with anti-TB medication. 4/10 (40%) AIF cases required operative stabilisation: 3 spinal and 1 above knee amputation. 2/10 (20%) CIF cases required operative stabilisation: 1 spinal and 1 pedal phalanx amputation. No patient died from OM.

Conclusion This is the first report of OM in a large cohort of patients with IF. While OM in IF is rare, the present reported experience from a national referral centre suggests that it may be increasing in incidence. IF practitioners should be vigilant for OM as a source of sepsis in this complex group of patients, since it carries significant morbidity.

Disclosure of Interest None Declared.

Abstract PTH-135 Table 1 Characteristics of OM cases: CRBSI rate, site and micro-organisms identified. (CRBSI=catheter related blood stream infection, OM=osteomyelitis, PN=parenteral nutrition)

		Acute	Chronic	p value
Number of CRBSI (including diagnosis of OM)		7	13	
Total days on PN at time of diagnosis of OM		1782.0	28532.0	
CRBSI rate (per 1000 catheter days)		3.9	0.5	
Time from sepsis (CRBSI and other) to diagnosis OM (months)	Median	2	1	0.476
	Range	1 – 4	0 – 19	
OM Site	Spinal	7	6	0.434
	Extra-axial	2	6	0.106
Micro-organisms identified	Staphylococcus	3	7	0.081
	Coliforms	2	8	0.005
	Fungi	2	4	0.290
	Other	4	8	0.111