REFERENCES
1 Cotton P *et al.* Results of the EPISOD Multicenter Sham-controlled Trial of Sphincterotomy in Patients with Suspected Sphincter of Oddi Dysfunction Type III presented at ACG San Diego October 2013
2 Bryce GJ, *et al*. Ampullary botulinum toxin injection in biliary sphincter of oddi dysfunction. *Pancreatology* 2013;13(1):e3

Disclosure of Interest None Declared.

OC-074 NUTRITIONAL OPTIMISATION AND PANCREATIC ENZYME SUPPLEMENTATION IN CHRONIC PANCREATITIS: ARE WE GIVING OUR PATIENT'S ENOUGH ADVICE?

[1]B Paranandi*, [2]PS Patel, [1]D Joshi, [1]GH El-Sayed, [3]K Koshy, [3]A Ghai, [1]MH Chapman, [1]SP Pereira, [1]GJ Webster, [1]GJ Johnson. *[1]Pancreaticobiliary Medicine, University College London Hospitals, London, UK; [2]Dietetics, University College London Hospitals, London, UK; [3]UCL Medical School, London, UK*

10.1136/gutjnl-2014-307263.74

Introduction There is a significant risk of malnutrition in patients with Chronic Pancreatitis (CP) with evidence to suggest that good dietary counselling for a balanced homemade diet is as good as commercial food supplements to improve nutrition. Pancreatic enzyme replacement therapy (PERT) is associated with improved absorption of nutrients as well as relief of GI symptoms. Proton pump inhibitors (PPI) improve the bioavailability and efficacy of PERT. Data regarding PERT compliance and education is lacking. We aim to determine the prevalence of exocrine insufficiency and compliance to PERT in patients with CP.
Methods Prospective study of consecutive patients with CP attending a tertiary clinic between October and December 2013. They were invited to participate in a face-to-face questionnaire study. Faecal elastase (FE) results were collated and the Malnutrition Universal Screening Tool (MUST) score was calculated.
Results A cohort of 86 patients identified were predominantly male (67%), White British (62%), median age 58 years (range 18–90), of socio-economic class (SEC) 8 (21% never worked/long-term unemployed) with educational level (EL) 1 (29% degree or equivalent). Aetiologies included alcohol (29%), idiopathic (25%), autoimmune (22%) and gallstones (11%). Median follow up was 27.5 months (range 0–151) from index appointment. 69 patients underwent routine measurement for FE, 61% (42/69) of whom were deficient (<200 μg/g) and 49% (34/69) severely deficient (<100 μg/g) suggesting exocrine insufficiency of the pancreas. 60% (25/42) of patients with confirmed exocrine insufficiency had active prescriptions for PERT, however only 40% (17/42) had PPI co-prescribed. Compliance and correct administration of PERT was observed in 56% (14/25) of patients. In those who were non-compliant or incorrectly administering PERT, nil patients (0/11) had undergone dietitian review within the previous 12 months and more than 50% (6/11) of these patients had MUST score ≥1 (conferring medium to high risk of malnutrition).
Conclusion Exocrine insufficiency is under-recognised in patients with CP and compliance with PERT is poor. Our data shows that the majority of patients who are not compliant with PERT are at medium to high risk of malnutrition. This highlights the need for structured dietetic involvement in the management of patients with CP in the clinic environment including biochemical testing of exocrine function, education about the natural history of CP, PERT administration and concomitant acid suppression.
Disclosure of Interest None Declared.

Poster presentations

Education and training

PTU-001 OVERUSE OF PROTON PUMP INHIBITORS AND STRATEGIES TO REDUCE INAPPROPRIATE PRESCRIBING

[1]C Owen*, [2]DJB Marks, [3]P Panesar. *[1]UCLH NHS Trust, University College London, UK; [2]Department of Clinical Pharmacology, University College London, UK; [3]Department of Pharmacy, UCLH NHS Trust, London, UK*

10.1136/gutjnl-2014-307263.75

Introduction Proton pump inhibitors (PPIs) are widely used but commonly over-prescribed.[1] A range of adverse effects are associated with their use, including susceptibility to C. difficile infection, fractures, pneumonia and electrolyte disturbances.[2]
Methods We investigated the extent and appropriateness of PPI prescribing at a university teaching hospital, and the impact on this of guideline implementation alongside formal teaching of junior doctors. A point-prevalence survey of PPI prescribing for in-patients across medical and surgical specialties was performed. Data collected included PPI prescription, whether this was initiated in hospital or the community, whether an evidenced-based indication was identifiable, and if the prescriber had documented an intended duration for its use. A local guideline was developed in line with current evidence, and national and international guidance. This was circulated to all prescribers by email and the hospital intranet, as well as face-to-face presentation to junior doctors alongside discussion around potential adverse effects. A further point-prevalence survey was undertaken after implementation.
Results A total of 274 patients were included in the first point-prevalence survey, and 264 in the second cycle. Initially, 52.7% of inpatients were prescribed a PPI; of these, 38.1% were commenced in hospital. An appropriate indication was documented in 34.7% and duration in 8.2%. Following introduction of a guideline and a programme of education, the proportion of inpatients receiving PPI therapy fell to 40.8% ($p = 0.008$), of which 28.4% were started in hospital ($p = 0.08$), 38.5% had an appropriate indication recorded, and 4.6% the duration.
Conclusion PPI prescribing rates among inpatients are high, and frequently not evidenced-based. There is also lack of consideration given to review of therapy and limiting provision to short courses. A combined approach of a focused guideline and educational strategies can reduce inappropriate over prescribing, but had restricted impact on the quality of documentation and specification of duration of therapy.

REFERENCES
1 Eid S *et al*. Patterns and predictors of proton pump inhibitor overuse among academic and non-academic hospitals. *Intern Med* 2010;49:2561–2568
2 Abraham NS. Proton pump inhibitors: potential adverse effects. *Curr Opin Gastroenterol* Nov;2012;28(6):615–20

Disclosure of Interest None Declared.

PTU-002 ERCP CANNULATION; EVALUATION OF A WIRE-LED TECHNIQUE FOR BILIARY ACCESS IN A TRAINING CENTRE

C Shekhar*, S Shetty, NC Fisher. *Gastroenterology, Russells Hall Hospital, Dudley, UK*

10.1136/gutjnl-2014-307263.76

Introduction A range of techniques have been described to achieve successful cannulation at ERCP, and when training in ERCP it is often difficult to select the optimum approach.[1] There are potential advantages to a wire-led approach and we have evaluated this in our unit in a training setting.
Aim To evaluate cannulation success rates for trainers and trainees using a wire-led technique as the default approach.
Methods A prospective evaluation was done with 2 experienced trainers and 2 trainees (previous experience of 50–100 ERCPs each). The sphincterotome was pre-loaded with a hydrophilic wire (in limited cases loop tip wire was used) and cannulation started with the wire extending 3–5 mm out of cannula. Attempts were then made to advance the wire deep into the bile duct before injecting any contrast or pushing the cannula through the ampulla. Trainees were allowed 6 min for cannulation attempts. If the wire-led approach failed then other techniques were used. Wire-led cannulation was considered successful only if no other techniques were required. Only cases with a 'virgin ampulla' were including in this study.
Results 85 cases were included over a 4 month period. Trainees were present in 51/85 (60%) cases. Overall biliary cannulation success was 78/85 (92%). Success rate was 45/51 (88%) if a trainee was present and 33/34 (97%), if no trainee was present. Independent success for trainees was 25/51 (49%), mostly using the wire-led technique (21/25) 84%. In cases where a trainer took over from a trainee, the wire-led approach was still successful in 13/26 (50%).

Overall success with the wire-led approach alone was 57/85 (67%); other approaches used in remaining cases included precut sphincterotomy, locked PD wire, and PD stent. A periampullary diverticulum was the most common cause for failure of wire-led technique; other common causes included stricture, floppy ampulla, or an impacted stone.

Median cannulation time was 6.5 min (IQR 4–10 min) overall and 5 min (IQR 3–10 min) for consultant-only cases. Immediate complications included false passage of wire (1 case, no further clinical events) and late complications: post ERCP pancreatitis (1 case, hospital stay 3 days, no further clinical events).
Conclusion Wire-led biliary cannulation, with selective usage of additional techniques, may allow a cannulation rate of >90% in cases with a virgin ampulla. The technique appears to be a useful training tool and has a low complication rate.

REFERENCE

1 Gastrointest Endoscopy *Clin N Am 2012 Jul*;22(3):417–34

Disclosure of Interest None Declared.

PTU-003 GASTROSCOPY CONSENT TRAINING FOR FOUNDATION DOCTORS: A NOVEL TEACHING STRATEGY

[1]DS Chilkunda*, [2]H Beal, [1]Y Khiyar. [1]*Gastroenterology, Hull Royal Infirmary, Hull, UK;* [2]*Endoscopy Unit, Hull Royal Infirmary, Hull, UK*

10.1136/gutjnl-2014-307263.77

Introduction Postgraduate Medical Education and Training Board (PMETB), now part of General Medical Council, reports on Foundation Schools have highlighted lack of consent training among Foundation Year 1 doctors (FY1s).[1] This can impact on patient safety and misguide expectations, thus adversely affecting patient experience. It could also affect FY1s' confidence as they often feel they obtain consent for procedures without adequate training. Robust consenting skills are integral to good medical practice and require urgent attention. Hence we developed a new teaching programme on consenting for diagnostic gastroscopy (DG), which is the commonest inpatient procedure undertaken in the endoscopy unit, and as this procedure is less complex with relatively rare serious complications.
Methods We initiated an *apprenticeship model* of training for consenting as part of mandatory FY1 induction. To facilitate this, we designed a formal assessment tool called Direct Observation of Gastroscopy Consent Taking Skills (DOGCTS). We developed a three-stage process. Stage 1: FY1s were provided small group teaching on consent and procedure. Stage 2: FY1s chose from available list of training slots, which were published after liaison between Endoscopy Unit and East Riding Medical Education Centre. Stage 3: FY1s observed one consenting process and DG by experienced endoscopist and underwent formal assessment using DOGCTS tool.
Results This pioneering programme was introduced to all FY1s working in Medicine and Surgery in HRI starting in August 2012. Since its inception, 139 FYs have been trained with 100% attendance rate. In order to avoid disruption to lists, only one FY1 was trained per list. Programme allowed FY1s to plan training around their clinical commitments. Successful completion of DOGCTS has been integrated into FY portfolio-requirements. Feedback from FYs has been positive and they have reported improved confidence. Patients have informally expressed that they had a better patient experience.
Conclusion Development of such a novel *apprenticeship model* allows for trainees and trainers to interact in an open, inclusive and non-threatening manner. It provides FY1s flexibility to manage their learning needs and trainers a chance to give formative feedback in real-time. Such a dynamic approach can not only improve confidence of FY1s but also instil public confidence in healthcare training. It has provided an excellent training opportunity in addition to being useful evidence for training-portfolios. It also caters to quality assurance and medico-legal aspects (pertaining to consenting) for NHS Trusts. We aim to undertake a formal survey of patient satisfaction annually and roll out this programme for flexible sigmoidoscopy consent as well.

REFERENCE

1 PMETBReport on Quality Assurance of FY1 programme visit to London deanery 2009

Disclosure of Interest None Declared.

PTU-004 APPLYING CLINICAL FRAMEWORKS AND MODELS TO IMPROVE THE SPECIALIST SCREENING PRACTITIONERS (SSP) SKILLS WHEN BREAKING BAD NEWS WITHIN THE BOWEL SCREENING WALES (BSW) PROGRAMME

[1]E Howells*, [2]S Darwin. [1]*Abertawe Bro Morgannwg University Health Board, Swansea, UK;* [2]*Bowel Screening UK, Public Health Wales, LLantrisant, UK*

10.1136/gutjnl-2014-307263.78

Introduction Communicating a life altering diagnosis to a participant is considered to be one of the most difficult aspects of the SSP role. Research would suggest that screen detected cancers are likely to be asymptomatic and in the absence of warning signs there is little time for people to prepare for such news. Screening diagnosis often show positive appraisals with an understanding that the disease may be curable through early diagnosis. The aim of this work is to determine the skills involved when the SSP breaks bad news to the participants within the bowel screening programme in Wales. Using personal reflection, clinical frameworks and models are assessed to