OWE-025 CATHETER RELATED INFECTIONS IN TYPE 2 INTESTINAL FAILURE PATIENTS ADMITTED TO A NATIONAL CENTRE

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10.1136/gutjnl-2018-BSGAbstracts.321

Introduction Management of intestinal failure (IF) requires safe and sustained delivery of parenteral nutrition (PN). Thus, long term safe central venous catheter (CVC) access is vital, with meticulous catheter care and salvage of infected catheters being of prime importance since catheter related blood stream infection (CRBSI) and loss of intravenous access are leading causes of morbidity and mortality in chronic IF. There are, however, no published data on the occurrence and outcomes of CRBSIs in patients admitted with acute severe (type 2) IF.

Methods This is a retrospective observational study conducted between Jan 2011 and July 2017. All new patients with type 2 IF admitted to a national IF Unit during these dates were included. A prospectively maintained database was used to record all confirmed CRBSI cases and clinical data. All new patients admitted with a CVC had paired central and peripheral cultures taken to identify CRBSI. Diagnosis of CRBSI was based on quantitative and qualitative analysis of paired central and peripheral blood cultures. The CVC was used only when CRBSI had been excluded or treated. A standardised 10 to 14 day catheter salvage treatment protocol involving CVC locks and systemic antibiotic administration was used to salvage infected catheters, as appropriate.

Results Of the 509 patients with type 2 IF admitted from another hospital to our IFU during the study period, 341 (54% female; mean age 54.6 (range 16–86 years) had an indwelling CVC. PICC and tunnelled CVCs were the most common (81.5%). Surgical complications and mesenteric ischaemia were the most common underlying aetiology. Sixty-five (19.1%) of patients had a diagnosis of CRBSI on the initial screening set of blood cultures and pour plates; the CRBSI had not previously been identified in the referring hospital. A successful CVC salvage rate of 91% was achieved in this cohort. Over a total of 23 548 subsequent catheter days during the 341 patients' stay in the IFU, there was only one CRBSI (0.042 per 1000 catheter days). There was no increased risk of future Home PN related CRBSI ($p=0.09$) or mortality ($p=0.4$) in those admitted with a CRBSI at admission, over a follow-up period of 216 944 catheter days.

Conclusion All patients should have screening cultures of CVC on admission to an IFU. When CRBSI is present on admission, a high rate of catheter salvage is possible. Stringent CVC care and aseptic strategies in a dedicated IFU can achieve a very low CRBSI rate during the subsequent inpatient stay. CRBSI at index admission to the IFU does not increase risk of future HPN CRBSI or death after discharge

OWE-037 MANAGING ISSUES WITH FOOD-RELATED QUALITY OF LIFE IN INFLAMMATORY BOWEL DISEASE – A QUALITATIVE STUDY

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10.1136/gutjnl-2018-BSGAbstracts.322

Introduction Inflammatory bowel disease (IBD) has a profound impact on diet and nutrition that creates limitations in psychosocial functioning and impacts quality of life (termed food-related quality of life, FR-QoL). The issues experienced and the management methods used by patients with IBD and healthcare professionals (HCPs) regarding FR-QoL are not well understood.

Methods Individual semi-structured interviews with 15 IBD patients reporting issues with FR-QoL; and two focus group interviews with 11 HCPs were audio recorded and transcribed verbatim. Pragmatic thematic analysis was used to analyse data, with NVivo 11 used for data management.

Results Fifteen patients with IBD (10 CD/5 UC) were purposively selected from UK hospital outpatient clinics (7 female, mean age 34.4 y; range 21–51 y). Individual interviews ranged from 39–70 min. Eleven HCPs (3 consultant gastroenterologists, 3 IBD registrars, 2 specialist dietitians, 2 IBD specialist nurses and one psychologist) participated in two focus groups over 2 hours each. Patients perceived IBD as having a direct impact on their diet, particularly their food choices and enjoyment of food. This limited their daily life such as going out, socialising with friends and family, or personal relationships. Several factors, including limited understanding of IBD impact on body function and food digestion, fear of triggering a flare through eating, anxiety about making the right food choices, were perceived to contribute to impaired FR-QoL. Patients attempted various methods to improve FR-QoL including trial and error, food avoidance or exclusion, reducing portion size or frequency of eating; but few approaches were perceived to have the desired improvement in FR-QoL. Limited or no dietary advice from HCPs left patients feeling that food-related issues do not receive the same level of attention as medical management. During the focus groups, HCPs identified the factors affecting patients' diet and FR-QoL that needed greater attention and they were: IBD-related (e. g. newly diagnosed, acute inflammation, functional symptoms, strictures and stoma) and non-IBD related (e. g. pregnancy, allergies, likes/dislikes). HCPs acknowledged FR-QoL advice as a low priority in a consultation. HCPs recognised insufficient time in clinical consultations to address more complex issues. Some felt inadequately prepared to offer diet-specific advice, or assumed that other members of the multidisciplinary team provide diet-related care and advice.

Conclusions Both, patients and HCPs emphasised the need for more individualised care in relation to food and IBD and required quality and timely sources of information. The development and testing of interventions designed to address FR-QoL is required.