correlated with 16 out of the 29 statements. 60% reported that food has association with disease activity. 89% were apprehensive of eating a particular food with the fear that it might trigger their IBD symptoms. Calcium and vitamin D intake from the diet was low, with a mean of 581.8 mg/day (recommended intake 1000 mg/day) and 282.9 IU/day (recommended intake 400 IU/day) respectively. 55% of patients with low calcium intake and 57% of those with a low vitamin D intake were not on supplements.

Conclusions This study highlights the high prevalence of food intolerances in the IBD community, resulting in high rate of food restrictions and less intake of foods rich in calcium and vitamin D. FR-QoL in IBD was poor. Food avoidances in IBD pose an important risk factor for poor nutrition, and majority of patients experience a low food related quality of life. Pro-active assessment of food intolerances, FR-QoL and dietary intake of calcium and vitamin D is essential to identify and rectify underlying insufficiencies.

Abstract PWE-115 Figure 1 Chart showing FR-QoL statement 11 vs disease activity [Disease activity (x axis): 1-4= active disease; 5&6= remission ($p=0.025$)]

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PWE-116 EVALUATING THE MANAGEMENT OF INPATIENTS WITH ANOREXIA NERVOSA: RETROSPECTIVE AUDIT USING MARSIPAN GUIDELINES

¹Buland Majeed*, ²James Hampton, ²Christian Dipper. ¹Newcastle University, Newcastle upon Tyne, UK; ²Royal Victoria Infirmary, Newcastle upon Tyne, UK

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Introduction The MARSIPAN guidelines were produced in response to evidence that anorexic patients on medical wards have sub-optimal outcomes. We aim to evaluate whether the care provided by a Gastroenterology ward in a busy teaching hospital meets recommendations provided by the most recent MARSIPAN guidelines.

Methods Retrospective case note analysis of patients admitted with severe anorexia nervosa (BMI <15) over 12 months. 9 patients meeting the inclusion criteria were identified, and their care was audited against a pro-forma that was crafted according to the MARSIPAN guidelines, discussion with clinicians and the wider evidence base.

Results Our findings suggest that there is variability in compliance with the recommendations set out in the MARSIPAN

guidelines. Some recommendations were met consistently; 100% of patients were seen by a dietitian and a senior psychiatrist at least once a week and had some common initial laboratory investigations (e. g. Full Blood Count, Urea and Electrolytes and Liver Function Tests). However, a number of important baseline investigations (such as the Sit-Up-Squat-Stand test [11.1%], serum amylase [0%], creatinine kinase [0%], serum ferritin and iron [33.3%], B12 and folate [33.3%]) were often missed. It was also rare for a full MSE to be documented (44.4%), or for a patient to see a senior psychiatrist twice a week or more (44.4%). Other important risk stratifying tools such as a baseline ECG (monitoring for prolonged QT) (66.6%) and sitting and standing blood pressure (33.3%) were also inconsistently carried out. In regards to nursing recommendations, the majority of patients were recommended bed rest (77.7%) and 100% had regular checks for pressure sores. However, only 22.2% were supervised for washes. 88.8% were supervised while they ate but only 22.2% were supervised for 30 min after (important to monitor for purging). Every patient received thiamine replacement as well as vitamin supplementation. The majority of patients were monitored daily for the first week of their admission for most markers of refeeding syndrome (U and Es [88.8%], calcium, magnesium and phosphate [77.7%]); however, only 33.3% had daily blood glucose measurements.

Conclusions Our findings, in the context of the wider evidence base, substantiate previous findings that anorexic patients on medical wards may receive sub-optimal care. In particular, important baseline investigations that are necessary to stratify risk are often missed and their importance needs to be better stressed. As the MARSIPAN guidelines state, 'patients near to death often look well', so being able to identify high-risk patients through rigorous investigation is key to optimising outcomes.

PWE-117 VITAMIN A DEFICIENCY-NOT JUST A DEVELOPING COUNTRY PROBLEM

Alexandra Marley*, Samuel Smith, Ruhina Ahmed, Sheldon C Cooper. Queen Elizabeth Hospital, Birmingham, UK

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Introduction Vitamin A and its metabolites are required for vision, cell function for growth, reproduction, haematopoiesis, and immunity. Vitamin A deficiency is known to be associated with increased morbidity and mortality from infectious diseases. It is also known to result in visual disturbance, classically night blindness, anaemia, growth retardation and reduced fertility. Vitamin A deficiency is primarily associated with the developing world, being seen in populations where malnutrition is commonplace. In 2002 it was estimated to affect 127 million preschool children and 7.2 million pregnant women worldwide. Vitamin A deficiency is being increasing seen in developed countries, invariably due to malabsorption with causes including chronic pancreatitis, chronic liver disease, intestinal failure and following bariatric surgery. Following bariatric surgery incidence of Vitamin A deficiency has been shown to be up to 69%.

Our aim was to review the vitamin A deficient patients in our population, a large tertiary centre in a developed country. We wanted to review this cohort in order to obtain