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. Proactive 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

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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

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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

information about the aetiology of their deficiency, their symptoms, management and response to supplementation.

Methods We reviewed all Vitamin A assay requests which were reported as <1 umol/L across a 5 year period between 2012–2016. We looked at the indication for the test, whether the patient was symptomatic, and what their symptoms were. In addition, we collected data regarding past medical history.

Results We identified 80 patients with Vitamin A deficiency. Of our cohort, 16 patients were symptomatic, presenting with predominantly visual symptoms: blurred vision, night blindness, recurrent miscarriage, poor vision and xerophthalmia. Vitamin A assays were requested by a variety of departments but most commonly by Liver, Gastroenterology/Nutrition and Ophthalmology. Only one of our symptomatic patient's Vitamin A deficiency was due primarily to poor intake and in one patient the aetiology of Vitamin A deficiency was unknown. Our other symptomatic patients had coexisting chronic illnesses which resulting in malabsorption.

Conclusion We demonstrated that Vitamin A deficiency is a cause of morbidity and potentially mortality in a developed country. We have also shown that the cause of deficiency in developed countries is not the same as in developing countries. We found the cause of Vitamin A deficiency to be overwhelmingly due to malabsorption, most commonly secondary to surgery or hepatobiliary disease.

PWE-118 HYPOPHOSPHATEMIA FOLLOWING IRON INFUSION IN PATIENTS RECEIVING HOME PARENTERAL NUTRITION IN A REGIONAL NUTRITION CENTRE

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Background Hypophosphatemia is a recognised complication of iron infusion. Patients receiving Home Parenteral Nutrition (HPN) due to intestinal failure are at additional risk of hypophosphatemia due to their underlying disease state. This study aimed to identify the extent of hypophosphatemia following iron infusion in this group of patients.

Methods The medical records of all HPN patients treated with parenteral iron infusion in the Department of Gastroenterology, Freeman Hospital, between April 2012 and February 2017 were retrospectively reviewed. Patients were identified from the regional HPN electronic database.

Patient's demographics, type and dose of iron infusion were noted. Blood test parameters including haemoglobin, ferritin, transferrin saturations and phosphate levels were analysed before and after iron infusion. Management of abnormal phosphate level was documented.

Degree of hypophosphatemia was categorised as severe (<0.30 mmol/L), moderate (0.30 to 0.59 mmol/L), mild (0.59 to 0.79 mmol/L). Normal phosphate level was defined between 0.80 to 1.50 mmol/L, elevated levels above 1.50 mmol/L.

Results Thirty five patients (19 females, 16 males), mean age 54, received iron infusions. All patients received Ferrinject iron infusion (Vifor Pharma UK Limited) at a dose appropriate to manufacturer recommendations, based on bodyweight. Results demonstrated that phosphate levels fell in 7 out of 35 patients (20%) following iron infusion; 2 with severe hypophosphatemia (5.7%) and 5 with mild hypophosphatemia (14.3%). Table 1 summarises the effect on phosphate level of

iron infusion. Twenty seven out of 35 patients (71%) had phosphate levels checked within 2 months post iron infusion.

One patient who developed severe hypophosphatemia had mild hypophosphatemia prior to iron infusion. All other patients had normal phosphate levels beforehand. Both patients with severe hypophosphatemia required intravenous phosphate replacement via manipulation of their HPN prescription. Of the 5 patients who developed mild hypophosphatemia, 4 resolved spontaneously, 1 required HPN prescription change. Time to normalisation of phosphate ranged from 4 weeks to 5 months.

Conclusions Severe Hypophosphatemia is a rare but potentially significant occurrence following iron infusion and can be prolonged in patients receiving Home Parenteral Nutrition. Numbers in this study are small and more studies are needed to investigate this further, including assessing the incidence using other preparations of intravenous iron in this group of patients. Routinely checking phosphate levels after iron infusions in this group of patients is probably warranted.

PWE-119 IRON ISOMALTOSIDE TO IMPROVE OESOPHAGOGASTRIC ADENOCARCINOMA RELATED ANAEMIA AND QUALITY OF LIFE DURING CHEMOTHERAPY

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Introduction Anaemia is common in oesophagogastric (OG) adenocarcinoma, increasing mortality, blood transfusions and reducing quality of life with no clear evidence exists for safe and effective treatment, especially for mild to moderate anaemia. This study assessed the efficacy of intravenous iron isomaltoside to improve anaemia, quality of life and prevent blood transfusions in OG adenocarcinoma.

Methods Anaemic patients with histologically proven OG adenocarcinoma were recruited before initiation of palliative chemotherapy. Patients were randomised to receive standard care or intravenous iron isomaltoside. Post-chemotherapy changes in haemoglobin, ferritin, transferrin saturations, blood transfusions and quality of life were recorded for 3 cycles of chemotherapy.

Results 27 patients were randomised to standard care (n=13) or intravenous iron (n=14). A non-significant decrease in haemoglobin was seen in the standard care group over three cycles of chemotherapy (mean difference -0.6 g/dL 95% CI -0.1 to -1.1 g/dL, p=0.336) compared to an increase in the intravenous iron group (mean difference 0.5 g/dL 95% CI -0.1 g/dL to 1.1 g/dL, p=0.903). An increase in ferritin and transferrin saturations above 20% was seen in the intravenous iron group by cycle one of chemotherapy with a greater and statistically significant increase in ferritin in the intravenous iron group (standard care 116 ng/mL versus intravenous iron group 770 ng/mL, p<0.05).

Blood transfusions were received by 7 patients (standard care n=4, intravenous iron n=3). No significant difference in the number and amount of blood transfused were seen (p=0.851). No patient received a blood transfusion after cycle one of chemotherapy in the intravenous iron group.

Quality of life improved in the intravenous iron group with physical well-being, emotional well-being, anaemia-specific