OTU-030 FAECAL MICROBIOTA TRANSPLANTATION FOR RECURRENT CLOSTRIDIUM DIFFICILE INFECTION: REAL WORLD UK DATA

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10.1136/gutjnl-2018-BSGAbstracts.444

Introduction recurrent *Clostridium difficile* infection (rCDI) is a medically challenging condition with limited therapeutic options often resulting in repeated admissions to hospital with associated high financial and patient burden. Faecal microbiota transplantation (FMT) has been shown to be highly effective treatment in placebo-controlled trials, however little real life data exists particularly from UK centres. We report our experience in a single tertiary referral centre.

Method Data was collected prospectively from January 2015 to November 2017 for patient demographics, comorbidities, route of FMT administration, 30 day and 1 year mortality. Primary endpoint was resolution of diarrhoea without relapse 10 weeks after first FMT. Resolution of diarrhoea without relapse 10 weeks after second FMT was also recorded.

Results 35 adult and 2 paediatric patients were approved for FMT for treatment of rCDI of which 35 patients underwent the procedure. 2 patients clinically deteriorated before FMT could be performed such that FMT became inappropriate.

27/35 (77%) were female, with a mean age of 67 y (range 4–91), and a mean ASA grade of 2.0 (0–4). Patients had received 3.1 (2–5) courses of antibiotics for *clostridium difficile* and 27 (77%) were external referrals. 32 FMTs were performed via colonoscopy and 3 via nasojejunal tube.

3 patients died within 30 days of FMT (mean ASA grade 3.3) but none directly related to the FMT or C Diff. There was once further expected death 90 days after FMT. No other major side effects or safety concerns were seen.

Of the patients who survived to day 30; 28 out of 32 (87.5%) patients had cessation of diarrhoea without relapse after 10 weeks. 4 patients had recurrent diarrhoea within 10 weeks of FMT of whom 2 had a 2nd FMT resulting in cessation of diarrhoea with no relapse after 10 weeks. The other two patients clinically deteriorated due to underlying medical conditions such that a 2nd FMT was inappropriate. All patients who survived had resolution of symptoms after their first or second transplant.

Conclusion FMT is a highly effective treatment for rCDI in the real world with resolution of symptoms and no relapse after 10 weeks achieved in 89.7% of patients undergoing 1st FMT increasing to 100% after a 2nd FMT.

No safety concerns were identified during the study period. The 3 deaths within 30 days of FMT highlight the comorbid population who develop rCDI and better patient selection is required to ensure appropriateness of FMT in high risk groups.

OTU-031 MY-IBD PORTAL: PROGRESS AND IMPACT UPDATE

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10.1136/gutjnl-2018-BSGAbstracts.445

Introduction Patients with Inflammatory Bowel Disease (IBD) often struggle with access to prompt advice regarding and place

a heavy reliance on overstretched services. We have a track record in guided self-management of IBD so explored whether this could be built into a novel patient-centred portal with direct on line access to a fully personalised health record, integrating individualised plans of care and disease monitoring tools.

Methods In a unique collaboration with local patients, the patient charity Crohn's and Colitis UK, health care and IT teams, we developed, implemented and evaluated a web based portal at Salford Royal. At the outset, a user group of patients was established and their views and needs were central to each step of the development, refinement and evaluation of the portal. From this group it was clear that there was a particular demand by IBD patients to have access to their health records and reliable information.

Results We have built and refined the 'MY IBD' portal, which is fully integrated with the electronic patient record and delivers:

1. Access to personalised information: diagnosis, visual aids and links to CCUK information resources
2. Immediate access to blood results, investigation results, clinic letters
3. Disease activity assessment tools
4. A personalised plan of care available online for the patient
5. Improved communication with the IBD team: messaging facility and trigger emails when disease activity scores are high.

720 patients are now using the portal. Overall usability was scored as excellent, showing patients were helped with decision-making. Improvements were seen in perceived support ($p=0.06$) compared to non-users with a trend to improved disease related knowledge ($p=0.14$). An average of clinic 2.9 attendances per year (2014–15) reduced to 0.6 attendances for portal self-management users (2016–2017) releasing over 500 clinic appointments. Satisfaction with self-management remains high with 98% of patients rating the process as good/excellent. User group sessions have captured value to patients. They expressed it had 'completely changed my care', 'having up to date information about your condition leads to less stress and better health' and 'puts patients back in control of their illness'.

The portal has also been refined for integration with the IBD registry.

Conclusions Patient experience and service have improved. Portal patients are more in control, with greater independence to self-manage through better understanding of their condition. Other Trusts are now seeking to adopt the portal and we welcome enquiries to establish it in other NHS sites.

Acknowledgments funded by CCUK, 'Living with IBD'.

OTU-032 INTEGRATED IBS CARE PATHWAY WITH DIRECT-ACCESS, DIETETIC-LED SERVICE – IMPACT ON PATIENT INVESTIGATION AND OUTCOMES

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10.1136/gutjnl-2018-BSGAbstracts.446

Introduction An integrated care pathway with direct access to a dietitian-led refractory IBS (RIBS) service was set up in Gloucestershire in 2016. GPs may refer patients <45 years with symptoms fulfilling ROME criteria for IBS which is refractory to first

line management (as per NICE guidance) and with faecal calprotectin (FC) level less than 150 ug/g directly to a dietitian-led clinic. The pathway and service aim to provide effective and expert management for this patient group, whilst reducing invasive investigation and referrals into secondary care gastroenterology clinics.

Methods GP requests for faecal calprotectin testing and subsequent referral to the RIBS service were audited over a 2 year period. Outcomes from intermediate FC results and referrals for lower GI endoscopy were audited annually for 6 month and 1 month periods retrospectively.

Results GP's requested on average 31 FC tests/month in 2016, rising to 54/month in 2017. 76% of these returned a negative (<50 ug/g) or intermediate (50–150 ug/g) result, with 60% of these patients being referred to the RIBS service. Proportion of patients with an intermediate FC referred directly to the RIBS service were similar in both audit periods (2016: 29%, 2017: 29.5%) Seven patients with an intermediate FC result had a high result at re-test three months later. These cases were discussed within MDT and referred for lower GI endoscopy as appropriate. Colonoscopy audit over a 1 month period prior to service set-up (May 2015) showed 100 patients <45 years had lower GI endoscopy, 35% of these met ROME criteria for IBS. One year later, 106 patients <45 years underwent lower GI endoscopy over one month with only 18% meeting ROME criteria for IBS. This figure fell again to 10% in May 2017. In all cases where symptoms met ROME criteria for IBS, lower GI endoscopy showed no major pathology. Over 300 direct access referrals have been managed through this pathway to date with 70% patients reporting satisfactory relief of IBS symptoms following dietary manipulation. Patients who do not respond are discussed in a consultant-led MDT with advice, review or investigation arranged as appropriate.

Conclusions The integrated care pathway and direct access RIBS service has led to a reduction in patients with ROME criteria IBS referred to GI consultants and for costly invasive lower GI investigation. GPs adhere to the care pathway and request FC tests appropriately as demonstrated by the 76% return of negative or intermediate results. Our data supports the validation of a higher negative FC cut off of 150 ug/g; no cases of IBD have been missed in this patient cohort to date. We continue to recommend ongoing education and audit prospectively to ensure optimisation of the service.

OTU-033 IMPACT OF POINT-OF-CARE TESTING FOR PATHOGENS IN PATIENTS WITH SUSPECTED GASTROENTERITIS: A RANDOMISED CONTROLLED TRIAL

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10.1136/gutjnl-2018-BSGAbstracts.447

Introduction Patients presenting to hospital with diarrhoea are routinely isolated as an infection control measure whilst awaiting results of laboratory stool tests which typically take several days. Novel rapid molecular testing platforms, which test comprehensively for gastrointestinal (GI) pathogens, generate a result in 1 hour, making them potentially deployable as point-of-care tests (POCT). Their use may therefore rationalise the use of isolation facilities.

Methods In this ongoing pragmatic, parallel group, open label, randomised controlled trial, adult patients presenting to hospital with acute diarrhoea (<14 days) were recruited and randomised 1:1 to receive either POCT with the FilmArray GI panel or to routine clinical care. Results of POCT were communicated to clinical and infection control teams. The primary outcome measure was duration of time in a side room and secondary outcome measures included turnaround time, proportion of patients with a pathogen detected, and proportion of patients correctly de-isolated. Statistical analysis was done using GraphPad Prism Version 7.

Result We performed an interim analysis using data collected from the first 100 patients. The groups (n=50) were well matched in terms of baseline characteristics. 34% of patients had inflammatory bowel disease. The median [IQR] turnaround time for results was 1.7 [1.6–2.3] hours in the POCT group and 61 [49–84] hours in the control group, p<0.0001. Pathogens were detected in 48% of patients in the POCT group and 20% in the control group, p=0.0057. The median duration of side room isolation was 2.1 [1.0–4.3] days in the POCT group (for those testing positive) compared to 2.7 [1.8–5.0] days in the control group, p=0.037. For those testing negative for pathogens, this was 1.4 [0.6–3.8] days in the POCT group versus 2.7 [1.8–4.9] days in the control group, p=0.0066. 62% of pathogen-negative patients were correctly de-isolated in the POCT group versus 20% in the control group, p=0.0012.

Conclusion POCT using the FilmArray GI panel resulted in a rapid turnaround time for results and an increase in the proportion of patients with pathogens detected. POCT was associated with a reduction in the duration of side room use. If these benefits are maintained in the full study and supported by health economic analysis, molecular POCT for GI pathogens should become standard of care.

OTU-034 IBD PSYCHOLOGICAL SUPPORT PILOT REDUCES IBD SYMPTOMS AND IMPROVES PSYCHOLOGICAL WELLBEING

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10.1136/gutjnl-2018-BSGAbstracts.448

Introduction Growing evidence suggests that psychological stress can increase activity of inflammatory bowel disease (IBD)^{1,2,3,4}. However there is insufficient access to psychological support services for IBD patients in the UK⁵. Current evidence demonstrates that psychological therapies improve quality of life in the short term, and supports the efficacy of antidepressant medication⁶ in improving disease activity.

Methods Our digestive disease unit at a major teaching hospital secured funding to pilot a Psychological Support Service for Patients with Inflammatory Bowel Disease (PSSPIBD) to provide outpatient psychological support to patients with IBD.

Between October 2015 to March 2017, 85 patients were assessed and treated by PSSPIBD, staffed by a psychiatrist (0.1WTE) and clinical health psychologist (0.3WTE) with special interests in IBD. Referrals were made for patients experiencing psychological difficulties related to their IBD by gastroenterologists, IBD nurses, pharmacists and stoma nurses.