steroids therapy, the second patient underwent surgery for a malignant stricture and the third patient had enteroscopy and removal of the capsule; biopsies of the stricture were in-conclusive. The overall cohort DY for all indications was 39% (n=377/958).

Conclusions This is the largest series from a DGH in England. Our data has shown that CE is safe, non-invasive and feasible in a district hospital setting. It has a good DY, acceptable to patient and allows adequate look at the small bowel. Recommendations: Despite the major role of CE in GI investigation, there is a lack of structured training. We recommend formal accreditation and training to be added to the Gastroenterology advance training curriculum.

PTU-074 MICROSCOPIC COLITIS: INCIDENCE AND BIOPSY PATTERN IN A DISTRICT GENERAL HOSPITAL IN ENGLAND

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Introduction Microscopic colitis (MC) is characterised clinically by chronic watery diarrhoea and usually by normal-looking colonic mucosa on endoscopy.¹ This creates controversy regarding the role of routine mucosal biopsy protocol. Despite an increasing incidence, understanding and awareness of MC remain low. The European Microscopic Colitis Group (EMCG) established a series of recommendations to enhance awareness about MC.²

Aim & methods We aim to evaluate the incidence of MC in our centre; a district general hospital serving a population of 2 50 000 in North east England. We retrospectively retrieved, reviewed and analysed data from all lower gastro-intestinal (GI) endoscopy reports and colonic biopsies histology reports for patients diagnosed with MC between January 2010 and December 2016. We assessed demographics, indications, endoscopy and biopsy histology reports of the cohort of patients with established MC.

Results 145 patients were identified. Three patients were excluded due to unavailable endoscopy reports leaving 142 eligible patients included in this service evaluation. The annual incidence rate of MC has increased by more than 5 folds over the six years period [Figure 1]. Females predominated the cohort with 93 patients (65.5%) with a mean age of 61 years (range 19–85). The mean age for males was 60 years (range 19–88). 137 patients underwent colonoscopy, while only five patients had flexible sigmoidoscopy. Indications were: chronic diarrhoea 83.1%(n=118), altered bowel habits 12.7%(n=18), anaemia 0.7%(n=1), per-rectal bleeding 0.7% (n=1), and Inflammatory Bowel Disease surveillance 2.8% (n=4). Endoscopy was normal in 85.2% (n=121), while 6.3% (n=9) of patients were found to have area of inflammation. Terminal ileal biopsies were performed in 12.7% (n=18) and were all negative.

Majority of patients (55.6%, n=79) were found to have lymphocytic colitis LC, while Collagenous colitis was demonstrated in 42.3% (n=60) of patients and only 2.1% (n=3) had a mixed histological picture of LC and MC reported. 89 patients (63%) had right, left and recto-sigmoid mucosal biopsies while the rest had random mucosal biopsies.

Conclusion Data from our centre showed annual increase diagnosis of MC. TI biopsies were all negative and therefore in-

conclusive in diagnosis of MC. In view of the lack of clear diagnostic biopsy protocol in normal lower GI endoscopy in patients presenting with chronic diarrhoea, either random colonic or segmental mucosal biopsies can be done to look for MC.

Abstract PTU-074 Figure 1 increase in the diagnosis rate of MC.

CC Collagenous colitis
LC Lymphocytic colitis

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PTU-075 WHAT IS THE BENEFIT OF TELEPHONE AND VIRTUAL IBD CLINICS IN A DGH?

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Introduction Inflammatory Bowel Disease (IBD) services across the UK are under increasing pressure. To improve efficiency, pathways of care have been proposed. However these are difficult to cost due to a lack of data on current service provision, leading to challenges with commissioning.

We set out to characterise our IBD service in a District General Hospital (DGH) setting, having recently implemented a new pathway to streamline the service. A second aim was to establish if our service met the NICE quality standard of seeing IBD referrals within 4 weeks.

Methods Prospective data from clinics at two DGHs were gathered from 92 patient journeys over 52 weeks. The activity of a new IBD helpline was analysed over a 28 week period and outcomes prospectively recorded. Specifically the activity avoided as a result of the helpline was analysed and costed. Finally, the outcomes from a new virtual IBD clinic were prospectively collected over a 10 week period.

Results 33% of clinic patients had IBD, of which 59% were in remission. 41% of patients were felt suitable for non-clinic follow-up. 76% were interested in the concept of 'self-management' during remission. 95% of patients rated the consultation experience as 'good' or 'very good'. There was an average 1 new to 4 follow-up encounters within the first year from referral; 26% were successfully conducted by telephone. Median time from initial referral to first outpatient contact was 9.1 weeks (4.9–19.9). 58% were not seen within 4 weeks of referral.