(range: 6 m–47.5 y). Most troublesome symptoms at assessment were bowel frequency of 4 or more times a day (88%), type 6 or 7 stool consistency (36%), urgency to defaecate (31%), faecal incontinence (21%) and fatigue (25%). Some women also reported urinary problems (17%) and sexual concerns (12%). Following a published algorithm, a median of 8 investigations were requested (range: 1–14): blood screen (97%), gastroscopy (75%), glucose hydrogen methane breath test (77%), SeHCAT scan (71%), faecal elastase (69%), flexible sigmoidoscopy (52%), colonoscopy (25%) and abdominal X-ray (18%). A median of four factors contributing to symptoms were found (range: 1–9) and 68% of women had more than three. The most common diagnoses were vitamin D deficiency (60%), treated with replacement; SIBO (54%), treated with antibiotics and bile acid malabsorption (52%), treated with bile acid sequestrants and low fat diet. The median number of consultations was 4 (range: 1–17). Median quality of life improved from 4 at first assessment to 6 at discharge ($p < 0.001$); the reduction in urgency, incontinence, tenesmus, frequency, diarrhoea and fatigue was statistically significant ($p < 0.05$).

Conclusions Bowel symptoms after cancer treatment affect many women. They can be discharged with symptom improvement using a systematic investigational and treatment approach. Earlier referral to specialist services is recommended.

PTU-119 UPPER GASTROINTESTINAL HAEMORRHAGE: IS THERE A WEEKEND EFFECT? A REVIEW OF TWO DISTRICT GENERAL HOSPITALS

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Introduction Upper gastrointestinal haemorrhage (UGIH) is a common emergency presentation with a mortality reaching 10%.¹ A 'weekend effect' has been described for UGIH with increased mortality rates for those admitted over a weekend.² These studies typically utilise information from national databases to describe this effect whereas this study sought to examine if there was a reproducible 'weekend effect' at two district general hospitals.

Methods Retrospective data was extracted from the endoscopy database for both hospitals in 2014, identifying all patients with an indication suggestive of UGIH. The Trust coding database was used to identify all patients with an ICD-10 code suggestive of UGIH. These datasets were amalgamated and electronic admission records subsequently analysed to exclude inpatient UGIH. Admission and discharge documentation, endoscopy reports, GP records and bereavements records were reviewed to confirm day and time of admission and endoscopy, and survival to 30 days. Chi-squared test was used to compare mortality between groups.

Results There were 552 admissions for acute UGIH in 2014, 518 patients underwent an emergency endoscopy, 23 either did not have an endoscopy or had an outpatient endoscopy, and 11 notes were unavailable or incomplete and thus excluded. There was no statistically significant difference in 30 day mortality for those admitted on a weekday (Mon 0000 – Fri 2359) vs a weekend (11.05% CI 7.98–14.79 vs

12.23% CI 7.92–17.79, $p = 0.68$ χ^2). Neither was there a statistically significant difference in 30 day mortality for those admitted out of hours (1700–0859) compared to in hours (12.60% CI 8.83–17.23 vs 10.39% CI 7.07–14.59 $p = 0.43$ χ^2). Although not statistically significant, there was an increase in 30 day mortality for those requiring an out of hours procedure (1800–0759) compared to day time (23.08% CI 14.89–33.09 vs 8.64% CI 6.16–11.72 $p = 0.19$ χ^2).

Conclusions This study found no correlation between the day or time of admission for UGIH and 30 day mortality, suggesting that despite reduced levels of staffing and endoscopic activity over the weekend or out of hours this had no impact on 30 day mortality. This may be explained by appropriate patient selection for urgent endoscopy.

PTU-120 IRON DEFICIENCY ANAEMIA IN RENAL CELL CARCINOMA

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Introduction British Society of Gastroenterology (BSG) iron deficiency anaemia (IDA) investigation guidelines recommend urinalysis to screen for non-visible haematuria. If detected, renal ultrasound is recommended to exclude renal cell carcinoma (RCC). Data on IDA in RCC however suggests that haematuria is rarely detected. We sought to identify the prevalence of IDA in RCC, and the frequency of haematuria in this subgroup.

Methods All newly diagnosed RCC at a single NHS Trust over a 3 year period (1/1/13–31/12/15) were identified from a prospective database of the Urology multidisciplinary meeting (MDM). A retrospective analysis of electronic notes, MDM outcomes, clinic letters, laboratory results, radiology reports, endoscopy reports and histology was undertaken. Information on demographics, symptoms and investigation results were collected. IDA was defined by a combination of microcytosis, hypochromia and low ferritin at time of clinical review, or a diagnosis of IDA on enteral iron replacement prior to clinical review.

Results There were 163 cases of RCC in 162 patients, mean age 63.7 years, 35% female. 43 patients (26.4%) were anaemic at diagnosis, IDA was present in 22 patients (13.5%). 59% of IDA patients had previously undergone gastrointestinal (GI) endoscopy: one colonic melanoma; all others were normal or benign. Haematuria was reported in 22.1% of RCC patients, and 13.6% of those with IDA (3 patients). Of these 3 patients, 2 had visible haematuria and 1 had non-visible haematuria.

Conclusions Anaemia is commonly found in patients diagnosed with RCC at presentation. In our study group approximately half of anaemic patients were iron deficient. The majority of these had been previously investigated with GI endoscopy without a significant GI cause identified. Haematuria was not reported in most patients with IDA suggesting urinalysis may not be a suitable screening investigation. This adds further weight to the hypothesis that IDA associated with RCC is not from occult renal tract blood loss but from deposition in, or consumption by, the tumour itself. We propose that renal tract ultrasound is considered in all patients with IDA without significant GI pathology