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PTU-125 IMPROVING QUALITY AND REDUCING FREQUENCY OF HOSPITAL CARE FOR ALCOHOL-USE DISORDER PATIENTS: A MULTI-DISCIPLINARY-TEAM APPROACH

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Introduction Patients with alcohol dependence often have complex health and social care needs resulting in frequent attendance at hospital. All too often care is aimed at optimising medical treatment of presenting conditions with little attention to, and planning for mitigation of causes, frequently exacerbated by non-medical problems. This failure to address the wider determinants of health often leads to a cycle of readmission. Therefore we aimed to improve the overall management of this patient group by bringing together a multidisciplinary team (MDT) to develop personalised multi-service, multi-professional care pathways.

Methods We developed a core multidisciplinary group with representation from our hospital hepatology team, our alcohol service, liaison psychiatry, occupational therapy, and our partners in primary care and homeless services. Other professionals and services were invited to the MDT meeting based on individual patient needs; this included the patient and or family and carers as appropriate. The purpose of this group was to develop a bespoke pathway of care with all current and future care providers, and foster an atmosphere for collaboration and mutual support. Our patients were often being cared for by multiple services, however much of this work was happening in isolation and was at times conflicting. Importantly, the patients were unclear where to go for what, and were utilising the ED as a failsafe when they were troubled.

Results MDT facilitated communication between services, professionals and the patient. This helped us provide planned rather than reactive care. For our 46 patients who have been presented at MDT, at six month follow-up we were able to demonstrate a significant reduction in hospital attendance and admission, resulting in ~120 less admissions and ~434 ED attendances across the acute trust; this equates to a *saving within the last 6 months of an estimated £63 600 on ED attendance alone.*

Conclusions MDT meetings are a familiar element of system delivery within acute hospitals. What is unique about our approach, and has resulted in significant quality improvement is that we invested time building relationships with people from organisations not traditionally included in acute hospital care planning. This included those working in homeless shelters, probation services, voluntary agencies, families and patients. We believe our success could provide the confidence for other acute care teams across the NHS to replicate our model.

PTU-126 IS THERE ANY ROLE FOR FLEXIBLE SIGMOIDOSCOPY FOR INPATIENTS WITH OVERT LOWER GASTROINTESTINAL BLEEDING?

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Introduction Inpatient flexible sigmoidoscopy (FS) is frequently requested to investigate overt lower gastrointestinal bleeding (LGIB), a condition where evidence based guidelines lack clarity. We sought to evaluate the benefit of FS in this setting, specifically: diagnostic yield, requirement for endoscopic therapy and comparison to diagnostic CT. Ultimately, to determine if FS is being over utilised.

Methods We retrospectively reviewed electronic healthcare records for all inpatients that underwent FS for LGIB (January 2016 – January 2018) at Barnet General Hospital. Recording the diagnosis on discharge; endoscopic findings; radiological findings and intervals between admission, endoscopy and discharge.

Results 87 inpatients underwent FS for LGIB (44 male and 43 female patients, mean age of 69 years (range=70)). Median length of stay was 6 days (range=126). The median duration from admission to FS and FS to discharge was 2 days (range=125) and 3 days (range=49), respectively. Accounting for multiple pathologies in a single patient, documented discharge diagnoses included: diverticular disease (35.8%), haemorrhoids (15.8%) inflammatory bowel disease (7.4%) malignancy (5.3%) and infective colitis (5.3%), no cause was found in 10.5%. 46 (52.9%) patients underwent a CT scan. Findings included: diverticular disease (31.3%), colitis (19.7%) and malignancy (4.9%). FS findings included diverticular disease (44.4%), colitis (17.8%), haemorrhoids (15.6%), polyps (2.2%) and malignancy (1.1%). 41.3% of CT scans were unremarkable. FS did not identify a cause in 66.7% of cases. 54.3% of findings on CT matched endoscopic findings. 2 (2.0%) patients required surgery. 2 (2.0%) patients required interventional radiology. 5 patients (5.7%) required endoscopic therapy (2 APC for radiation proctitis, 1 haemorrhoid banding, 1 post-polypectomy bleed, 1 rectal packing), 4 (80.0%) had active bleeding during FS; with no association with comorbidities or anticoagulation. 24 (27.6%) of patients required blood transfusion. 23 (26.0%) patients underwent outpatient colonoscopy.

Conclusions FS has limited diagnostic and therapeutic yield, identifying a cause for LGIB in a third of inpatients. Most patients did not require endoscopic therapy and were not actively bleeding during FS. Endoscopic therapy was more likely if bleeding was from a rectal source (radiation proctitis, haemorrhoids, recent polypectomy). We recommend inpatient pathways incorporate clinical examination for assessment of haemorrhoids and CT scan, with most patients being managed conservatively followed by outpatient colonoscopy. Inpatient FS for LGIB in the majority is not recommended. Further studies and clear national guidance is required.

PTU-127 DOES A DIRECT-TO-SCOPE PATHWAY SIGNIFICANTLY REDUCE TIME TO DIAGNOSIS FOR PATIENTS WITH POSITIVE COELIAC SEROLOGY?

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Introduction NICE Coeliac Disease Quality Standard 134 (QS134) states that: Patients with suspected coeliac disease (CD) should undergo endoscopic (OGD) intestinal biopsy within 42 days of referral and, if confirmed, should receive specialist dietary advice. Given that UK incidence of CD is 19:100,000, our trust would expect 60 new cases of CD per year. In October 2017, a direct-to-scope referral was introduced to streamline the diagnostic pathway. We sought to evaluate the impact of this pathway on the time to histological diagnosis and dietitian review.

Methods All adults referred with positive coeliac serology initiated in primary care from April-September 2017 were compared to those referred following the introduction of the new pathway. Data for the two cohorts was collected from e-case notes using a standard audit tool. This included time from referral to: OGD; confirmation of diagnosis; clinic review; dietician review and vaccination advice.

Results 27 patients (cohort A) were identified in the 6 months prior to October and 17 patients (cohort B) in the following 4 months. In cohort A 2 patients did not attend their appointment and 5 patients underwent OGD prior to referral. From April-September we also identified 10 patients with positive coeliac serology that, to date, have not been referred. The results are shown in table 1.

Abstract PTU-127 Table 1

	mean (days)	range	mean (days)	range	
Result-GP referral	30	7–159	29	9–140	0.98
GP referral-OGD	39	4–89	24	4–43	0.010
GP referral-clinic	43	13–81	49	27–67	0.22
GP referral-confirmation of CD	68	12–189	39	21–69	0.0012
GP referral-dietician review	104	98–230	52	30–71	0.0035
Patients discharged after initial review	30.4%		92.3%		
Patients given vaccination advice	25.0%		69.2%		

Conclusions The use of a direct-to-scope pathway significantly reduces time to diagnosis. This change in the pathway allows clinic and dietician review to occur simultaneously, resulting in referral to treatment time within 18 weeks. The only patient in cohort B outside the 6 week target to endoscopy did not tolerate their index OGD and required a repeat endoscopy. Written confirmation of diagnosis now occurs prior to the initial clinic review, helping reduce unnecessary follow-up for patients with uncomplicated CD. We hope continued use of this pathway may also reduce the number of patients with positive serology not referred from primary care.

PTU-128 COMPLEX COLORECTAL POLYP SERVICE IN THE SOUTHEAST REGION: FIRST ANNUAL RESULTS OF A NEW SERVICE

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Introduction Recently published Guidelines of the British Society of Gastroenterology (BSG) establish the standards of a Complex Colorectal Polyp (CCP) Service. We assessed the provision of a new CCP Service at East Kent University Hospitals Foundation Trust.

Methods We prospectively recorded our performance for resections of CCPs (low risk >2 cm-4cm/high risk >4 cm) from November 2016 to December 2017 and measured it against BSG standards: 1) interval time from referral to resection within 8 weeks, 2) resection types employed, 3) short term outcomes (follow up within 3–6 months) and complications.

Results 105 patients underwent 121 resection procedures (56 males, mean age 70.5±11.5 years). The interval time from referral to resection procedure was delayed >8 weeks in 36/105 patients (34%). Polyp resection was completed in one session in 116/121 cases (96%),>1 session in 2 cases and on 3 occasions the procedure was abandoned (suspected invasion).

We performed 77 piecemeal-Endoscopic-Mucosal-Resection (pEMR), 8 hybrid pEMR/Endoscopic-Mucosal-Ablation (EMA), 8 hybrid pEMR/Endoscopic-Submucosal-Dissection (ESD), 8 Trans-Anal-Submucosal Endoscopic Resection (TASER), 7 free-hand ESD, 2 Laparoscopic-Assisted-Colonoscopy-Polypectomy (LACE) and 11 Serrated Cold Piecemeal Emr (SCOPE). Median overall polyp size was 3 cm (range 2/12). For 13/38 polyps with high-risk features (median size of 5 cm, range 4–12), otherwise destined for tertiary referral or surgery, we selected more endo-surgical and/or en-bloc resections: (TASER=7/ESD=4/LACE=2).

12 Polyps proved to have malignant features (11 within the high-risk group), all discussed at Colorectal MDM: 6/12 underwent colectomy, 2/12 local radiotherapy (T1 >1 mm +adverse histological features/patient preference) and 4/12 endoscopic surveillance (T1 <1 mm, no adverse histological features). In total, 7/105 (6.6%) patients had surgery (6 malignant/1 benign polyps).

Of 98/105 patients treated: 41 (42%) did not have follow-up within 6 months, 31 (30%) are scheduled for follow-up and 27 (28%) had timely follow-up with a low (range 3–10 mm) recurrence rate (4/27, 13.8%), easily treated. No perforations or mortality were recorded. Four cases of delayed bleeding (3.8%) were documented: endoscopy was required in 2 for clipping.

Conclusion Our results demonstrated a safe and effective provision of a CCP service (96% complete excision in a single visit), as a result of a synergy between gastroenterologists and surgeons. However, we noticed an inadequate booking process, currently addressed by implementing new CCP pathways and setting up a CCP MDM.

PTU-129 SPECIALIST COMPLEX POLYP CLINIC: A TERTIARY REFERRAL CENTRE EXPERIENCE

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Introduction Specialist pre-operative clinics are an established part of cancer care. Limited or no data is available on the impact of specialist clinic for complex colo rectal polyps. Our tertiary referral centre is experiencing increasing numbers of elderly, co-morbid patients with benign complex polyps. Optimising a successful, appropriate and safe management strategy is fundamental to offering a quality service.

Objective The purpose of this pilot prospective study was to assess the impact of a specialist complex polyp clinic on the resulting management strategies and and outcomes for patients.

Methodology A monthly specialist complex polyp clinic was established in January 2016. If indicated, endoscopic polyp assessment was performed on the same day. Inclusion criteria was defined as complex, large polyps in a patient with multiple co-morbidities. Patient demographics, polyp data and outcome were retrieved from the complex polyp clinic database.

Results A total of 64 patients attended the complex polyp clinic between January 2016 and December 2017. Most cases discussed were tertiary referrals (88%). Median age of our cohort was 74 years. Median size of the polyp was 20 mm (mean 31, SD 30 mm). Most of the polyps were in colorectum (92.2%), and the remainder were in the upper GI tract. Main reasons for a review in the clinic were: discussion of therapeutic options (surgery vs endo therapy) and the risks/benefits of therapy 80%, discussion of surveillance 25%, discussion of previous endoscopic results 16%. A quarter of the patients who attended the clinic had a polyp assessment on the same day. 58% of patients underwent nurse led pre-assessment during the clinic visit.

Following the clinic discussion and polyp assessment 47% (30/64) of patients had a successful endoscopic resection of polyps, 12.5% (8/64) had laparoscopic surgical resection, 30% (19/64) were recommended for surveillance colonoscopy or CT colonography, 6% (4/64) declined to have proposed therapy,1.5% (1/64) of cases no therapy was recommended,1.5% (1/64)awaiting to have a combined laparo endoscopic therapy and 1/64 (1.5%) patient passed away due to ischaemic heart disease before their proposed treatment.

Conclusions The complex polyp clinic provides an opportunity to discuss the therapeutic options in the management of complex benign polyps and to assess the fitness of the individual for proposed therapy. Furthermore, a comprehensive endoscopic polyp assessment could be carried out during the clinic visit to plan appropriate therapy.

PTU-130 EFFICACY OF SEROLOGY-BASED DIAGNOSIS FOR COELIAC DISEASE IN CHILDREN IN A TERTIARY UK CENTRE

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Introduction ESPGHAN published guidelines in 2012 allowing for non-tissue diagnosis of coeliac disease (CD) in symptomatic children with high levels of circulating tissue transglutaminase antibodies (TTG), anti-endomysial antibodies (EMA) and positivity of HLA-DQ2 or DQ8. This is contrary to adult guidelines, where histological diagnosis is recommended. This study assessed the use and effectiveness of non-tissue diagnosis in a tertiary centre.

Methods A retrospective review of all children (age <18 years) in a single centre newly diagnosed with CD between 1/2/12 to 31/12/16 with 1 year follow up. If endoscopy was performed, 2 biopsies were taken from the duodenal cap and 4 from D2 or lower, as per protocol. Histology was analysed using the modified Marsh grading system. Data were collected using electronic patient records. Analysis was performed using SPSS version 21 (Chicago, USA). Significance was defined as $p<0.05$.

Results Of 82 newly diagnosed patients, 12 were asymptomatic children identified via screening and therefore excluded, leaving a cohort of 70. 61% (n=43) were female. Median age at diagnosis was 7.58 years (range 0.86–17.66). The commonest presenting symptom was abdominal pain, with over 50% of patients affected. All had TTG measured at baseline, with a mean[SD] of 88.0 [46.6] U/ml, 7 being the upper limit of normal (ULN) and 128 the maximum recorded with our assay. 35.7% (n=25) had a TTG <10 times ULN. These children all had endoscopy, as per ESPGHAN guidelines. Overall, 76% (n=53) were diagnosed by endoscopy and biopsy. No patients had concomitant pathology diagnosed and there were no operative complications.

47% (n=33) had complete serological testing; 34% (n=24) fulfilled ESPGHAN serological diagnostic criteria. 24% (n=17) were given a diagnosis of CD without small bowel biopsies (figure 1). 75% of patients (n=8) who met the criteria were offered non-biopsy diagnosis and all, but one preferred this option. At maximum follow up, none of the patients diagnosed serologically have required endoscopy.

There was a significant fall in TTG from baseline (mean 87.3, SD 46.5) at 6 months (mean 23.5, SD 29.7; p=0.003) and at 12 months (mean 12.5, SD 22.1; p=0.017). This decrease was significantly greater in children diagnosed serologically both at 6 months (mean [SD] 82.8 [42.0] vs 57.6 [43.6]; p=0.04), and at 12 months (mean [SD] 93.0 [41.2] vs 67.4 [45.6]; p=0.049).