Posters

PWE-001 ARE FEMORAL TUNNELLED CENTRAL VENOUS CATHETERS SAFE TO USE FOR HPN?

¹Arun Abraham*, ¹David Sawbridge, ¹Annabelle Coultier, ¹Antje Teubner, ³Ashley Bond, ¹Michael Taylor, ^{1,2}Simon Lal. ¹Intestinal Failure Unit, Salford Royal NHS Foundation Trust, Salford, UK; ²School of medical science, University of Manchester, Manchester, UK; ³Royal Liverpool Hospital, Liverpool, UK

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Background Patients with Intestinal Failure (IF) require reliable intravenous access for provision of Parenteral Nutrition. Venous access for Home Parenteral Nutrition (HPN) patients with Type 3 IF can be compromised due to thrombosis of deep veins. Preferred choice of veins for central venous catheter are the supra cardiac veins. Femoral tunnelled CVC are avoided due to concerns of catheter related blood stream infection (CRBSI) and are considered as a last resort when all other thoracic CVC access is exhausted. We assess the outcomes of tunnelled femoral catheters in our cohort of HPN patients.

Methods We did a retrospective analysis of a prospectively collected data of all HPN patients and venous access from January 2013 to December 2018 managed at a National HPN Unit. The details of venous access, complications of CVC, sex and details of stoma extracted from database.

Results In a cohort of 9 HPN patients with tunnelled femoral CVC, 6 were females and 3 were males leading to a total of 8418 days. A total 3 episodes of CRBSI were recorded in 1 patient. All of the 3 episodes (methicillin – sensitive *Staphylococcus aureus* (MSSA), *Escherichia Coli* and CNS) were successfully salvaged. The average no of days for femoral CVC was 935 days. The rate of CRBSI was 0.35 per 1000 catheter days. 8 patients had stoma or open abdominal wound. There were no episodes of ipsilateral femoral DVT. The CVC was replaced for 2 patients due to fracture of CVC.

Conclusion Tunnelled femoral CVC CRBSI rate (0.35) is comparable to thoracic veins CVC CRBSI rate(0.31) in our unit. Furthermore femoral access could be considered as a reliable access to provide HPN. It may be considered as an option if more than 2 thoracic deep veins are occluded to prevent complete occlusion of SVC. We feel tunnelled femoral CVC is a safe option to consider for HPN

PWE-002 HOME PARENTERAL NUTRITION IN THE PALLIATIVE PATIENT: A SINGLE CENTRE EXPERIENCE

Jamal Al-Asiry*, Cairiona Bennett, Clare Donnellan, Peter Mooney. Leeds Teaching Hospitals Trust (LTH), Leeds, UK

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Background Few studies have assessed the benefit of nutritional support in advanced cancer patients. We aimed to investigate survival in patients receiving parenteral nutrition (PN) for intestinal failure (IF) in the palliative setting and identify factors associated with improved survival.

Methods Patients were identified from a database in an IF tertiary referral centre. Data were collected retrospectively for all cancer patients who commenced PN for a palliative indication between 01/01/2011 and 31/03/2018. These included; age on commencing PN, time from diagnosis (first MDT) to

commencing PN (lead time), initial hospital admission length, cancer type, mechanism of IF, and date of death. Co-morbidities were recorded using the validated Charlson index. Mechanism of IF was subdivided into 3 groups; obstruction (n=30), short bowel syndrome/high output fistula (n=22), and other (n=4). Cancer diagnoses were grouped into gynae and peritoneal (n=26), gastrointestinal (GI) (n=18), and other (n=12). Categorical variables were compared using fisher's exact and continuous variables using Kruskal-Wallis. Survival rates were compared using Kaplan-Meier curves and cox regression. P<0.05 was used for significance.

Results 56 patients (mean age 57; 71.4% female) were identified during the study period. Patients with gynae/peritoneal primary were older when commencing PN (p0.02) compared to other tumour groups. Patients with gynae/peritoneal cancers also had a longer lead time prior to starting PN compared to the other groups (Kruskal-Wallis p0.01; Kaplan Meier p0.04).

However once PN was started there was no difference in mortality between groups. 90 day mortality was 38.4% for gynae/peritoneal, 27.7% for GI, and 25.0% for others (p0.633). 150 day mortality, the rate was 61.5% for gynae/peritoneal, 44.4% for GI, and 50.0% for others (p value 0.515). Kaplan-Meier curves appeared to diverge between gynae/peritoneal and GI cancers although this wasn't significant (p0.56) and cox regression showed near identical survival between these groups (HR 1.02 p0.97).

There was also no difference in mortality rates for different mechanisms of IF, 90 day mortality was 36.6% for obstruction, 31.8% for short bowel/fistula, and 0.0% for others (p0.372). 150 day mortality was 60.0% for obstruction, 45.5% for short bowel/fistula, and 50.0% for others (p0.647).

Conclusions Patients with slow growing gynae/peritoneal cancers have been diagnosed with cancer for longer than other cancer types prior to commencing palliative PN. However once PN is commenced survival between groups in this cohort was similar. An extended follow up and a larger sample size may yet demonstrate significant differences. A prospective study is required to assess for other factors that may influence survival.

PWE-003 HOW SUCCESSFUL IS BEDSIDE NASO-JEJUNAL PLACEMENT IN A NEURO-CRITICAL CARE UNIT (NCCU)?

Marta Alves*. Cambridge University Hospitals, Cambridge, UK

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Introduction Enteral nutrition (EN) is the optimal route of feeding in critical care patients and naso-gastric (NG) feeding is the primary route¹. Mechanically ventilated patients are at risk of delayed gastric emptying (DGE). In 2016, in our NCCU, the delay inserting endoscopically-placed naso-jejunal tubes (NJTs) led to the use of unnecessary parenteral nutrition (PN) in 15% of cases². Bedside self-propelling NJT were piloted and a protocol was written for their use and insertion. **Methods** This retrospective audit determined whether self-propelling NJT insertion protocol was being adhered to appropriately and the success rate of insertion.

Patients admitted to NCCU between October 2016-March 2018 were included if they met the following criteria:

1. Failure to absorb gastric feed ($\geq$ two gastric residual volumes –GRVs– >400 ml within 24 hours), despite dual prokinetic therapy (metoclopramide and erythromycin for 2–8 hr).

2. Those at high risk of aspiration of gastric feed.

Results 8 patients failed to establish adequate NG feeding due to ≥ 2 GRVs above 400 ml; all attempted bedside NJT insertion but only 5 were successful. It was noted when more training was provided, 3 NJT were placed within a 2 week period.

Delays in NJ placement, medical team shifts and inadequate use of prokinetics (<24 h) often led to lower GRVs, excluding patients from NJT placement. This resulted in patients restarting gastric feeding with varied success.

Prior to NJ insertion, 7 patients received adequate doses of prokinetics. 1 patient had a reaction to erythromycin. For this patient, metoclopramide was not effective enough except when a higher dose was given (20 mg vs 10 mg). This suggests scope for optimising the prokinetic dose to ensure the success of NJT placement.

Mean time between NJ insertion and X-ray position confirmation was 10 hr. This considerably improves nutritional delivery as in the previous service evaluation, patients awaiting endoscopically placed NJT had no nutrition for – days ².

Conclusions Bedside NJ insertion can be a useful tool to facilitate the provision of enteral nutrition, avoid long gaps in nutrition in critically-ill patients and avoid PN. However, widespread adoption of this protocol requires training and engagement of medical staff and protocol optimisation.

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PWE-004 DOES ROBOTIC SURGERY LEAD TO MORE PATIENTS REQUIRING PARENTERAL NUTRITION? ANALYSIS IN A TERTIARY CENTRE

Aaron Bancel*, Saba Boyer-Masfari, Ikram Nasr. *Guy's and St Thomas' NHS Trust, London, UK*

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Introduction Robotic surgery techniques have revolutionised Urological surgery. It has thus been used more frequently in centres that are able to offer the technique. It is suggested that robotics increases the accuracy of dissection and helps enhances the preservation of neurovascular bundles.(1) Anecdotally it was noted that patients who had robotic surgery developed more nutritional complications than those patients who underwent non-robotic surgeries previously. On review of the literature, rates of paralytic ileus in non-robotic surgeries range from 7–8% respectively. (2 3)

Method We analysed all patients who underwent robotic Urological surgery at Guy's & St Thomas' NHS Trust in the last 2 years (robotic cystectomies and prostatectomies). All patient post-operative notes were analysed and screened for the development of post-operative ileus and/or the requirement of Parenteral Nutrition (PN).

Results In total, 136 patients were analysed. Of these, 19 patients developed post-operative ileus (16 male, 3 female, average age 69.5), 13 developed post-operative ileus requiring PN (9 male, 4 female, average age 68.2) and 2 patients developed bowel obstruction which did not require nutritional support (both patients were male, aged 64 & 65 respectively).

Therefore, 23.5% of patients developed post-operative ileus, which is higher than reported non-robotic post-operative ileus rates.

Conclusion Our results suggest that robotic surgery may lead to more patients requiring nutritional support post-operatively than those who had non-robotic surgery, according to previously reported rates. The increased proportion of ileus could be related to operating time. It is possible that with increased usage of the robotic technique, the operating time will decrease and thus levels of ileus will reduce. This also emphasises the importance of the involvement of a dedicated Nutrition team in these patients, which should include a Medical Consultant and highly-specialised pharmacists, nurses and dietitians. Further studies in larger cohorts are required.

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PWE-005 GASTROSTOMY USE IN THE SOUTH WEST FOR MOTOR NEURONE DISEASE PATIENTS

¹James Gulliver*, ¹Abdul Dinata, ¹Oliver Bendall, ²James Bebb, ²Tracy Lee. ¹University Hospitals Plymouth NHS Trust, Plymouth, UK; ²Royal Cornwall Hospital NHS Trust, Truro, UK

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Introduction Malnutrition is a significant problem for patients with motor neurone disease (MND). NICE recommend gastrostomy insertion for nutritional support is discussed at an early stage before respiratory impairment and weight loss increase the risks beyond acceptable limits. The ProGAS study found no mortality difference between percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG) tube placement, nor did it provide definitive guidance concerning timing and route of gastrostomy insertion. This study reviews the use of gastrostomy tubes in the South West between two large hospitals.

Methods Databases of MND patients from the Royal Cornwall Hospitals NHS Trust (RCH) and the University Hospitals Plymouth NHS Trust (UHP), together serving a population of 2 million people, who had gastrostomies inserted from 2011 to 2018 were included. Data was assimilated to include demographics, type of gastrostomy used, months to insertion from diagnosis, sedation use and mortality. Results were analysed using Microsoft Excel and described in means (+/- standard deviation). Two-tailed t-tests assuming unequal variance were performed in order to establish if there was a statistically significant difference between the means. P values < 0.05 were regarded as significant.

Results The RCH cohort (n=19) demonstrated a female preponderance (58% v 42%) and mean age of 70 (+/- 9 years). 42% received PEG, 47% RIG and 11% surgical gastrostomies. The mean insertion time from diagnosis was 10 months (+/- 11 months), with 30 day mortality 0%. Overall mortality was 58% in the study period with mean survival from diagnosis 28 months (+/- 29 months).

The UHP cohort (n=54) were 54% male, 46% female, with a mean age of 67 years (+/- 12 years). 85% received