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 (<24h) 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

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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

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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