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.

REFERENCES

- McClave, S. *et al.* (2016) Guidelines for the provision and assessment of nutrition support therapy in the adult critically ill patient: society of critical care medicine and American society for parenteral and enteral nutrition. *JPEN* **40**(2):15–11.
- Service E. How successful is gastric feeding in mechanically ventilated traumatic brain injury patients? Talk. Dietitians in Critical Care conference, UK. Nov 2016

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.

REFERENCES

- Challacombe BJ, Rose K, Dasgupta P. Laparoscopic radical and partial cystectomy. *Actas Urol Esp [Internet]*. 2005;**1**(4):188–95.
- Roghmam F, Trinh QD, Braun K, von Bodman C, Brock M, Noldus J, *et al.* Standardized assessment of complications in a contemporary series of European patients undergoing radical cystectomy. *Int J Urol*. 2014;**21**(2):143–9.
- Chang SS, Cookson MS, Baumgartner RG, Wells N, Smith JA. Analysis of early complications after radical cystectomy: Results of a collaborative care pathway. *J Urol*. 2002;**167**(5):2012–6.

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

PEG and 15% RIG. The mean insertion time from diagnosis was 11 months (+/- 14 months), with 30 day mortality 1.9%. Overall mortality was 87% with mean survival from diagnosis 23 months (+/- 16 months).

The majority of PEG insertions were arranged on dedicated lists with anaesthetic cover (83% vs 17%) compared with only a minority of RIG insertions (18% vs 82%). There was no significant difference between time to insertion ($P = 0.78$) and survival from diagnosis ($P = 0.61$) between the 2 cohorts.

Conclusions Gastrostomy use in the South West is safe, with mortality rates below quoted literature. Gastrostomy practice differs between the 2 hospitals in the approach used but time to insertion and mean survival was not different. The authors intend to pursue a joint referral pathway for gastrostomy assessment. This would improve data collection quality, allowing future analysis of standardised variables to ascertain the most effective use of gastrostomies in these patients.

PWE-006 THE T-PIECE PULL TECHNIQUE REMOVAL OF PEG BURIED BUMPERS – A QUICK NOVEL ENDOSCOPIC TECHNIQUE

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Introduction Buried bumper syndrome (BBS) represents a rare, but potentially serious complication in percutaneous endoscopic gastrostomy (PEG) tubes. In BBS there is a growth of the gastric mucosa over the inner bumper of the PEG tube, affecting 0.–% of PEG tubes.

Options for the management of BBS include the insertion of a jejunal extension, surgical or endoscopic removal. Endoscopic removal represents the most attractive option as it is the least invasive procedure to remove the buried bumper (BB). Several endoscopic techniques have been described

including endoscopic dissection (ESD) of the overgrown tissue, a “Push-pull T technique”, or the use of a papillotome placed through the PEG tube to cut the overgrown tissue.

The novel T-piece pull technique has been developed as a modification of the “Push-pull T technique” without the need for external support.

Methods A prospectively kept database was analysed for all BBS patients undergoing the procedure between September 2016 to January 2019. Primary outcome measures were technical success, procedural times and adverse events. Secondary outcome measures were BB morphology based on Paris polyp classification and PEG dwell time.

Description of technique (Figure 1)

1. Following endoscopic assessment of the BB, the PEG tube is exposed and cleaned.
2. The PEG tube is cut close to the abdominal wall.
3. Biopsy forceps are passed through the PEG tube into the stomach under direct endoscopic vision.
4. The forceps pull a 10mm snare passed down the biopsy channel of endoscope out of the stomach through the PEG tube.
5. A 2cm piece of the redundant PEG tube is cut and placed through the snare and closed to create a t-piece.
6. The snare is pulled firmly through the PEG into the stomach, removing the buried bumper.

Results A total of 27 cases for BBS were undertaken with the T-Piece pull technique, on 18 females and 9 males with a mean age of 43 (range 1–8). The median PEG tubes dwell time was 14 months. Procedures were performed with conscious sedation in 19% and enhanced sedation with anaesthetic support in 81%. BB morphology was Paris 1s in 9, 2a in 16 and 2b in 2. The median procedure time was 18 minutes (range 1–5). The technical success was 93%. 2 failed procedures required surgical removal, both 2b lesions. Complications occurred in 2 cases, 1 episode of sepsis and 1 abdominal pain.

Abstract PWE-006 Figure 1