following admission (16/26); overall survival to end August 2018 was 54% (14/26).

Conclusions This audit highlights the significant cost and complexity of patients with T3IF on HPN requiring in-patient admission to hospital. With an increase in prevalence of T3IF of 20% per annum nationally, it is vital that HPN centres are sufficiently resourced and funded to facilitate management and care of this complex cohort of patients.

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PWE-013 NUTRITIONAL CARE PATHWAYS OF PATIENTS WITH MALIGNANT BOWEL OBSTRUCTION: EXPERIENCE FROM A UK TERTIARY-REFERRAL CENTRE

¹PS Patel*, ¹K Fragkos, ¹N Keane, ²K Cauldwell, ¹F O'Hanlon, ¹J Rogers, ¹S Obbard, ¹J Barragry, ¹G Sebeos-Rogers, ¹S Mehta, ¹F Rahman, ¹S Di Caro. ¹GI Services, University College London Hospital, London, UK; ²Palliative Care Central and North West London NHS Trust, London, UK

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Introduction Emerging evidence is gathering for the use of parenteral nutrition (PN) in patients with malignant bowel obstruction (MBO) who have lost nutritional autonomy and developed Intestinal Failure (IF). There is limited evidence

describing the outcomes for MBO patients who are not referred for PN. We aimed to examine nutritional care pathways of MBO patients by referral for PN and appropriateness of referral/non-referral for PN.

Methods Retrospective cohort study of adults (≥ 18 yrs) admitted to University College London Hospital, admitted with MBO between 1.1.16- 31.12.16 with any readmissions up to 31.12.17. Data were analysed by comparing patients who were referred (R) and not referred (NR) for PN.

Results 72 patients with 117 MBO admissions (mean $\pm$ SD age: 63.1 $\pm$ 13.1 yrs, 79% female), with median no. of admissions/patient: 1 (range: 1–6). 24/72 patients were in R group. Predominant primary malignancies were gynaecological and gastrointestinal (76%). 83% of MBO patients had metastases and 61% were located subdiaphragmatically. All patients were at high risk of malnutrition using UCLH nutrition screening tool (score=8, a score of ≥ 7 indicates high risk of malnutrition) and mean weight loss on admission was 7%. Discussion of PN at MDT (21 vs. 4%, $P=0.02$) and dietetic contact (94 vs 41%, $P<0.0001$) were more likely to occur in the R group. In 13/69 MBO admissions in NR group, the reasons for non-referral to the Nutrition team are unclear. 20/24 referred patients received inpatient PN, and 10 patients went home with PN. The remaining patients did not go home on PN as BO resolved or they were approaching the end of life. There were no differences in weight or BMI by PN referral groups. In all patients, median weight on admission was 55kg (range: 3–90), and 5–5.8kg at 0–3- and 3–6- months follow-up. Overall survival was 4.7 (1–5.2) months, with no differences by referral groups (Fig 1).

Abstract PWE-013 Figure 1 Kaplan Meier Curve of survival by referral for parenteral nutrition.

Conclusion All MBO patients presented with high risk of malnutrition on admission. Less than half were referred for PN. Patients who received a dietetic review and when PN was discussed at MDT were more likely to be referred for PN. It was unclear in some cases why patients were not referred for PN. This suggest that timing of referral and integration of nutritional care, not just PN, into clinical management discussion at MDT is crucial. Not all patients referred to the Nutrition team were discharged on HPN based on judicious review of each case.

PWE-014 IS HOME PARENTERAL NUTRITION BURDENSOME IN ADVANCED CANCER PATIENTS WITH MALIGNANT BOWEL OBSTRUCTION?

¹PS Patel*, ¹N Keane, ¹K Fragkos, ¹F O'Hanlon, ²K Cauldwell, ¹J Rogers, ¹S Obbard, ¹J Barragry, ¹G Sebeos-Rogers, ¹S Mehta, ¹F Rahman, ¹S Di Caro. ¹GI services, University College London Hospital, London, UK; ²Palliative Care Central and North West London NHS Trust, London, UK

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Introduction Use of home parenteral nutrition (HPN) in advanced cancer patients with malignant bowel obstruction (MBO) who have developed intestinal failure (IF), is controversial. Controversies relate to financial, cultural, and ethical issues, including the risk that HPN is burdensome for the patient and carer. We examined what burdens are placed when HPN is initiated.

Methods Retrospective cohort study of adults admitted to University College London Hospital with MBO and started on HPN between 1.1.16 and 31.12.16 with readmissions until 31.12.17. Data were analysed using mean (SD), median (range) and n (%). Survival was examined using Kaplan Meier curves.

Results 10 patients with 20 MBO admissions were started on HPN (mean±SD age: 55.3±13.9 yrs, 80% female). Primary malignancies were 50% gynaecological and 50% lower GI with metastases (70% subdiaphragmatically). Median weight and BMI on admission were normal (54.8 kg, 4–7 kg; 19.1 kg/m², 1–3), though, patients presented with significant weight loss (9.1%, 3.–1.1%). HPN was more likely to be set-up on the 2nd admission with BO. HPN delayed inpatient discharge by median 2 days (–) due to lack of communication within and between Oncology and Nutrition teams. Median duration of HPN was 196 days (–51). Patients were on PN 7 days/wk (–), with n=8/10 utilizing nursing input for PN (dis)connection. For those who were nursed this meant –4 visits/wk by homecare nurses for PN (dis)connection. Reasons for stopping HPN completely included: death (n=5), were end of life (n=2) or eating (i.e. BO resolved), suggesting flexibility to stop HPN to patients' circumstances. Decision to stop HPN was not contentious in any case. Post HPN discharge, median readmissions were 3, and 0 due to HPN. Follow-up appointments were mostly in oncology than nutrition clinics (5.5 vs 3 follow-ups). There was a 3m longer survival in those on HPN (median survival: 9 m for HPN patients, 4m in patients not on HPN). No HPN complications were observed over the 1 yr follow-up.

Conclusion HPN is more likely to be set up during the 2nd admission for MBO. HPN did not place a substantial burden on the patient with regards to readmissions and follow-up visits to hospital or discharge delays. Nursing visits, in addition to other service visits (e.g. GP, palliative care) could be

perceived as burdensome by patients. These factors could potentially be alleviated by seamless integrated care among services. Survival was longer in HPN patients. Further research in larger settings and quality of life factors need to be weighed in decision making.

PWE-015 THE CAUSE OF DEATH IN PATIENTS ON HOME PARENTERAL NUTRITION IN THE NORTH-EAST OF ENGLAND

¹Elisabeth Bluethner, ¹Satyasheel Ramful*, ¹Hayley Leyland, ¹Christopher G Mountford, ²Colette L Kirk, ²Lisa Gemmell, ¹Nicholas P Thompson. ¹Department of Gastroenterology, Freeman Hospital, Newcastle upon Tyne, Newcastle Upon Tyne, UK; ²Department of Dietetics, Freeman Hospital, Newcastle upon Tyne, Newcastle Upon Tyne, UK

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Introduction Home total parenteral nutrition (HPN) is indicated for patients with severe intestinal failure. The service at the Freeman Hospital, Newcastle upon Tyne covers a wide area encompassing Northumberland, North Cumbria, Durham, Gateshead, North Yorkshire, Tyneside, Wearside and Teesside. A previous European study,¹ had suggested deaths in HPN patients after 2 years of HPN were most likely due to PN. The aim of our study was to determine whether the cause of mortality for patients who had been under our service for HPN was linked to complications of HPN therapy.

Methods This study retrospectively looked at all patients who were started on HPN by the service from 1996 until August 2018 and identified all patients who had died. The case notes were reviewed and if the cause of death was not clear from the notes, their general practitioner (GP) surgery was contacted to gain further information.

Results 88 patients were identified as having died whilst or after being on HPN. The mean age was 58 years old and their average time on HPN was 25 months. There was an even gender split of 44 in each category.

The three most common categories for HPN indication for the patients were cancer (32/88, 36%), inflammatory bowel disease (13/88, 15%) and mesenteric ischaemia (11/88, 13%).

Most of the deaths were attributed to cancer (45/88, 51%) and non-PN/non-malignant related (29/88, 33%). There were two deaths attributed to complications of being on parenteral nutrition. For nine cases, GP surgeries did not have any further information on cause of death. We did not receive a response regarding three patients despite contacting GP surgeries

Table 1 showing cause of death according to number of years on PN

Abstract PWE-015 Table 1

	< 1 year	– year	> 2 years
Cancer	32	7	6
Non-PN related	7	6	16
PN related	0	0	2
Unable to determine	4	5	3

The table above reveals that as time on HPN increased the commonest cause of mortality changes from cancer to non-PN related complications.