PWE-099 ANTIBIOTICS FOR SIBO: DO WE FIX IT?

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Introduction There is a lack of literature regarding symptomatology following diagnosis and treatment of small intestinal bacterial overgrowth (SIBO)¹. This service evaluation aimed to assess local outcomes.

Methods Retrospective assessment of patients referred for hydrogen (H₂)/methane (CH₄) breath tests (BT) for SIBO was performed. From 201–017, 132 patients (F=94, M=48) were tested at the University Hospital of North Durham. 50 g glucose in 250 ml water was the substrate used for the tests. A positive BT was defined as an increase in hydrogen or methane of ≥10 ppm with a starting baseline <12 ppm following a 12 hour fast and other accepted pre-test preparation. Main outcomes assessed were results from BTs, treatments given and outcomes following treatment. Quantitative statistics were not used due to small populations.

Results 159 BTs were conducted, with 28 reported as positive for SIBO. 79% of these patients were treated with relevant antibiotics (abx) (– week course). No major adverse effects of treatment were described. Following a positive BT, patients were reviewed after 4.5 months (range 0–2 months). Subsequent follow up was 10 months (range –5 months) from initial test.

It is possible (though implausible) that all those returning for follow-up experienced symptom resolution. With this bold assumption, 23% of patients (Outcome Category (OC) 1,2) may have experienced lasting improvement (Figure 1). We can be confident that some improvement was seen in 41% of the patients treated (OC 2,3,4). Disappointingly no patients were documented to have symptom improvement at second follow-

up (OC 5). In 41% of patients no improvement related to abx treatment was reported (OC 6,7).

Conclusions Abx can provide short term symptom relief in some patients with abdominal symptoms; however, this is generally not a long-term solution. There are important limitations of this work including the retrospective nature, variable follow-up duration and lack of validated symptom assessment. Findings do, however, support the need for improvements in understanding of maintaining a healthy microbiome. This maintenance is likely dependent on the aetiology of the underlying cause of the SIBO².

REFERENCES

1. Shah SC, Day LW, Somsouk M & Sewell JL. Meta-analysis: antibiotic therapy for small intestinal bacterial overgrowth. *Aliment Pharmacol Ther.* 2013; **38**:92–34.
2. Rezaie A, Pimentel M & Rao S. How to test and treat small bowel bacterial overgrowth: an evidence-based approach. *Curr Gastroenterol Rep.* 2016; **18**:8.

Gastroenterology Service**Orals****OTH-01 A COMPLEX LOWER GASTROINTESTINAL POLYP MDT IMPROVES EVIDENCE-BASED DECISION MAKING AND EFFICIENCY OF ENDOSCOPY SCHEDULING**

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Introduction Demand for lower gastrointestinal (LGI) endoscopy in the UK has doubled (1). In an increasingly ageing and co-morbid population, multi-disciplinary team (MDT)

Abstract PWE099 Figure 1 Symptom outcomes following treatment for positive H₂/CH₄ BT. 1=No follow-up; 2=Short term improvement with no further follow-up; 3=Short term improvement but symptom return by second appointment; 4=Improvement only while taking abx; 5=Stated symptom improvement at second follow-up; 6=Abx not taken but symptoms improved; 7=No improvement.

discussion is necessary to plan complex endoscopic resection (ER) within 8 weeks in an already overstretched service (2). We established a LGI complex polyp MDT meeting to meet this need and assessed if this process improved utilisation of therapeutic endoscopy points and scheduling efficiency.

Methods A weekly MDT including schedulers, clinical endoscopists, specialist registrars and 2 expert endoscopists (EE) was held (Oct'18 – Feb'19).

All cases discussed at the MDT had an initial referral for endoscopy. Cases were divided into known polyp/s to discuss ER, those with previous complex ER requiring surveillance and patients with CT colonography (CTC) positive for polyps. Polyp complexity was assessed by SMSA score (3). Patients for ER were assigned a points value for scheduling and a decision made if an EE was needed. Outcomes were compared to the initial referral to look for changes in management plan and points allocated.

Results In total, 115 patients were discussed (Table 1). Median SMSA score for each group was 8. 7 patients did not require further endoscopy. 15 patients were referred for ER. 35 patients had previous ER and surveillance scheduled. Compared to the original referral, the management plan for 57 patients (49%) was changed saving 55 points. 90 cases required an EE saving 35 points.

Conclusions A complex polyp MDT changed the original management plan in half of patients referred and improved capacity with 3 lists saved (12 points/list) for polyps requiring expert ER. Such an MDT should be used in all centres that perform complex, high volume endoscopy.

Abstract OTH-01 Table 1 Polyp characteristics and outcomes from MDT discussion

	Polyp/ s (73)	Surveillance (34)	Abnormal CT (8)
Median no. of polyps (range)	2 (–0)	2 (–6)	2 (–7)
Median SMSA score (range)	8 (–5)	8 (–4)	N/A
Change to original referral, n (%):	33 (45)	22 (65)	2 (25)
Therapeutic endoscopy	11	2	2
Surveillance	16	19	0
Other investigations	2	0	0
Surgery	2	0	0
Discharged	2	1	0
Cases booked on expert/non-expert list	60/7	26/7	4/4
Cases downgraded/upgraded from original referral	29/4	20/2	2/0
No. of points originally allocated	201	86	21
No. of points actually allocated	169	66	18
Points saved on expert list	20	14	1
Points saved on all lists	32	20	3

1. Scoping the future. CRUK, 2015

2. BSG guidelines for management of large non-pedunculated colorectal polyps. Rutter MD, Chattree A, Barbour JA et al. Gut 2015

3. The SMSA scoring system for determining the complex of a polyp. Gupta S, Miskovic D, Bhandari P, et al. Gut Suppl 2011

OTH-02 REVIEW OF THE NURSE ENDOSCOPIST SERVICE MODEL AT A LARGE ENDOSCOPY CENTRE

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Background Endoscopy services are under immense pressure with ever increasing demands. Using the services of non-medical endoscopist has proven to be safe beyond reasonable doubt.¹ Considering the increasing demand for endoscopy, there has been a national drive to increase the number of Nurse Endoscopist (N.E). We performed an audit of current practice to evaluate the efficiency of our N.E work force. The aim is to identify the areas where the team can be supported to work more efficiently and their role can be made more fulfilling.

Methods We prospectively collected data on utilization of endoscopy services over a period of 45 days at 1 of the 4-endoscopy sites of our trust. A note was made of the number of units booked versus those performed, procedures not attended or cancelled and the average duration for completion of lists and average time taken per unit of endoscopy. This data was further sub-classified as per the title of the Endoscopist performing the list into Gastroenterologist, Surgeon and N.E.

Results A total of 1126 patients were booked for endoscopic procedures out of which 56 did not attend and 96 were cancelled. Average age of patients was 62 years (range 95 -16 years) with 53.9% (n=607) being females. These procedures accounted for a total of 1524 booked units distributed further as 275 for N.E (18%), 945 for gastroenterologist (62%) and 304 (20%) for surgeons. The actual units performed compared to units booked were 80.4% (n=221) for N.E, 89.2% (n=843) for gastroenterologist and 86.5% (n=263) for surgeons. The average numbers of units booked on a single list for N.E was 7.4 (range –2) while actual performed were 6 (range –). Similarly, for gastroenterologist these figures were 10.9 (range –5) vs. 9.9 (range –9) and for surgeons 11.3 (range –3) vs. 9.7 (range –3) respectively. The average time taken to perform each unit of the list for N.E was 32 mins (p<0.0001) while the same for gastroenterologist and surgeon was 21 mins (p<0.0001) and 18 mins (p<0.0001) respectively.

Conclusion N.Es are a valuable resource for delivering endoscopy services. It appears that the effective utilization of their skills, which is essential for the success and fulfilment of the potential of their role, has not been achieved. The current model of utilizing the true potential of N.E is neither effective nor productive. We have now adopted a new training model for N.E at our trust, which not only allows improved technical skills but also teaches efficient time management, lesion recognition and decision-making. All these elements are equally important to ensure effective and safe use of this skilled workforce. 1 Williams, J. et al, 2009. Effectiveness of nurse delivered endoscopy: findings from randomised multi-institution nurse endoscopy trial (MINuET). *Bmj*, 338, p. b231.