has allowed us to develop the service in order to increase capacity, reduce pressures on unplanned care and reduce costs. **Method** 12 weeks of prospective data were collected on patients receiving elective paracentesis. Recommendations made on analysis of this data (Excel) led to changes in the standard operating procedure and a further 6 weeks of prospective data collection closed the PDSA cycle.

Results In the initial data collection, 31 elective paracentesis were completed on 15 individual patients. Drains were in situ for a median of 24 hours, necessitating an overnight stay. On average 10,966ml of fluid were drained (range 4324ml – 19692ml). The rate of ascitic drainage plateaued at 8 hours, with an average, 74% (range 53%-100%) of total ascitic fluid drained at this point. From this we hypothesized that adequate drainage could be achieved with a day case procedure.

During the second data collection, 27 elective paracentesis were completed on 12 individual patients with drains in situ for 8 hours. On average 8,123ml of fluid were drained (range 3903ml – 20996ml). If we extrapolate this data over 12 weeks we could accommodate a 74% increase in capacity between study groups.

20% albumin replaced 4.5% to reduce volume infused, therefore reducing further time constraints on admission. On average 3 bottles of 4.5% albumin were used in the initial study group and only 2 bottles of 20% in the second study group. This led to a cost saving, on average of £57.06 per paracentesis, this becomes substantial when added to the cost savings of day case versus overnight stay.

There were no clinically significant changes in renal function or haemodynamic parameters in either data set. 86% of patients initially studied had a UKELD score greater than 49 with a median value of 54.5 (range 4–0).

There were 7 repeat attenders in the initial group and 4 in the second, attending 3 and 4 weekly, respectively. Only one patient was studied in both data sets with increased drain frequency from monthly to fortnightly.

Conclusions Both data sets have shown variability of ascitic fluid volume and drainage rates. We must continue an individualised approach to refractory ascites, but changes to our standard operating procedure have increased elective paracentesis capacity by 74%, reduced pressure on unplanned care and reduced costs by £793.06 per paracentesis. The changes are safe with no clinically significant renal function or haemodynamic deterioration. It is difficult to attribute cause to changes in paracentesis frequency given the multiple confounding factors related to ascites production.

PTU-089 HEPATITIS B SCREENING PRIOR TO RITUXIMAB AND SUBSEQUENT MANAGEMENT TO REDUCE THE RISK OF REACTIVATION

¹Grace Dolman*, ²Ioannis Theocharopoulos, ¹Patrick Kennedy. ¹Barts Liver Centre, London, UK; ²Barts and the London School of Medicine and Dentistry, London, UK

10.1136/gutjnl-2019-BSGAbstracts.448

Introduction Hepatitis B (HBV) reactivation can occur during immune suppression in patients with serological evidence of current infection (HBsAg positive) or past exposure to HBV (HBsAg negative, anti-HBc positive). Rituximab poses a particular risk, with reported rates of reactivation >10% in those with positive HBV markers. Reactivation can result in delays

to ongoing treatment and, in small numbers of cases, acute liver failure leading to transplantation or death.

Methods We performed a retrospective audit of screening for HBV markers prior to rituximab and management of patients at risk of HBV reactivation in an East London NHS Trust serving a multi-ethnic population. Our cohort was identified from a search of electronic records for a pharmacy order for rituximab placed in 201–018 across clinical specialties.

Results 461 patients were included, of whom 191 were male (41%). Ethnicity was as follows: British or Irish 169 (36.6%); Asian or Asian British 118 (25.6%); Black or Black British 44 (9.5%); Any other white background 44 (9.5%); Mixed 4 (0.9%); Chinese 1 (0.2%); Any other ethnic group 22 (4.8%); Not known 59 (12.8%). Screening was adequate in 384 patients (83.3%). 62 patients (13.4%) had undetectable HBsAg, but no record of anti-HBc. 2 patients (0.4%) were not tested for HBsAg, but were anti-HBc negative, making past/current infection unlikely. 13 patients (2.8%) had no record of either HBsAg or anti-HBc testing. 339 patients (72.7%) had undetectable HBsAg and anti-HBc. 3 patients (0.7%) tested positive for HBsAg, all of whom received appropriate antiviral prophylaxis. 42 patients (9.1%) tested positive for anti-HBc, with undetectable HBsAg. It was probable that passive transmission had occurred as a result of immunoglobulin infusions in 2 cases and was confirmed in 3 cases. Repeat anti-HBc was pending in 2 patients. 5 of these 7 patients received antiviral prophylaxis. Anti-HBc positivity was thought to be due to past HBV exposure in 35 patients (7.6%). One patient was already on Truvada for HIV infection. A further 27 patients received antiviral prophylaxis with either lamivudine, entecavir or tenofovir, although in 7 of these the prophylaxis commenced after rituximab infusions had started. No prophylaxis was given to 8 patients at risk of HBV reactivation based on serological markers (21% of at risk group). There were no episodes of reactivation during the audit period.

Conclusion In this audit of a multi-ethnic population receiving rituximab, we found that screening was adequate in only 83% of cases. Of those adequately screened, nearly 10% were at risk of hepatitis B reactivation with B-cell depleting therapies. 21% of those at risk did not receive appropriate prophylaxis. We propose cross-specialty guidelines and safety checkpoints in pharmacy and infusion units to reduce the risk of HBV reactivation in this patient group.

PTU-090 THE USE OF FAECAL CALPROTECTIN AS A SCREENING TOOL FOR REFERRING PATIENTS WITH POSSIBLE IBD

Darren Fernandes*, Aarati Mathew, David Elphick. Chesterfield Royal Hospital, Chesterfield, UK

10.1136/gutjnl-2019-BSGAbstracts.449

Introduction Faecal calprotectin (FC) has been shown to have high sensitivity and specificity for differentiating between Inflammatory Bowel Disease (IBD) and functional gastrointestinal disorders. However, there are different thresholds for interpreting FC results. The National Institute for Health and Care Excellence (NICE) therefore proposed the role of an intermediate range for values with Turvill et al. suggesting a cut off of >100. At Chesterfield Royal Hospital, no such intermediate range has been determined. The purpose of this study was thus to analyse FC results and referral outcomes to

discover if using a cut off value of >100 was adequate in diagnosing IBD.

Method A retrospective analysis was conducted for all patients in Chesterfield who had a FC requested by their GP between July and December 2017. The notes of those referred and seen in clinic were then analysed.

Results 498 patients had a FC performed by their GP. 107 patients were seen in clinic, 58 were female and 49 were male. Ages ranged from 16 years to 89 years with FC results from <8 to 1086. 9 patients in total were diagnosed with IBD. If a cut off FC >100 were used; 42 of these patients would have been referred with 6 being diagnosed with IBD. 65 would not have been referred but 3 would have IBD, giving a sensitivity of 66.67% (95% CI 29.93% to 92.51%) and a specificity of 63.27% (95% CI 52.93% to 72.78%). The positive predictive value of our test would therefore be 14.29% (95% CI 8.93% to 22.07%) with negative predictive value of 95.38% (95% CI 89.02% to 98.14%).

Conclusion Our study has shown that using a cut off value of >100 for FC values will result in a lower sensitivity when compared to data from other groups. However, a larger cohort of patients will need to be retrospectively analysed to determine whether a cut off value for FC of 100 should be used or if it should be lowered in order to improve sensitivity and specificity in diagnosing patients with IBD. In addition, we have discovered that FC testing is being incorrectly performed in patients who meet other diagnostic pathways and so further advice and guidance needs to be given regarding its use.

PTU-091 RIGHT HEMICOLECTOMY IN CROHN'S DISEASE – ARE WE FOLLOWING ECCO GUIDELINES?

Sarah Flatley*, Ian Reilly. *Countess of Chester Hospital, Chester, UK*

10.1136/gutjnl-2019-BSGAbstracts.450

Introduction Despite recent advances in medical therapy, approximately 80% of patients with Crohn's disease will require surgery within 20 years of diagnosis. Surgery is not curative and clinical and/or endoscopic recurrence occurs in the majority of patients. Correct pre-operative planning and post-operative care has a major impact on the outcome of such treatment. The aim of this study was to compare local practice in the Countess of Chester Hospital with published ECCO guidelines, to identify opportunities to improve care.

Methods This was a retrospective analysis of all patients with Crohn's disease that underwent a right hemicolectomy between January 2013 and December 2017 at the Countess of Chester Hospital. Patients were identified by obtaining a list of right-hemicolectomy specimens from the histopathology department. Patient notes were reviewed to ascertain patient demographics, pre- and post-operative treatment, and follow-up endoscopy.

Results A total of 14 patients were identified for this study. Age range was 2–5 with a male to female ratio of 4:3. The Montreal classification varied widely. Only 8/14 (57%) of patients had received an immunomodulator pre-operatively and 2/14 (14%) were on a biologic. 10/14 (71%) of patients were not given either an immunomodulator or biologic post-operatively. Follow-up endoscopy occurred in 7/14 (50%) patients. 3 of these were within 6 months and 4 were within 12 months of the operation date. 3/7 (42.9%) of patients had

evidence of recurrence on endoscopy. None of the patients had a Rutgeerts' score generated.

Conclusions This study demonstrates the variability of management of patients with Crohn's disease post-operatively. Our results show that over 60% of patients were not on any medical treatment pre-operatively. In addition, over 75% of patients continued to remain on no maintenance after their operation. Only 50% of patients underwent a follow-up endoscopy within 12 months of their operation date and a Rutgeerts' score was not generated in any of these patients.

PTU-092 EXPLORING ACCESS TO SECONDARY CARE SERVICES FOR PATIENTS WITH ESTABLISHED INFLAMMATORY BOWEL DISEASE

Sharon Gethins*, Sanjeev Pattni, Richard Robinson. *University Hospitals Of Leicester, Leicester, UK*

10.1136/gutjnl-2019-BSGAbstracts.451

Introduction The Inflammatory Bowel Disease (IBD) Standards of Care recommend that defined arrangements are in place to allow for direct admission or assessment to a gastroenterology unit for patients with UC or Crohn's. Currently in Leicester there is no facility for rapid access or direct admission to inpatient GI services. The aim of this study was to establish how patients with (IBD) accessed secondary-care services when admission was required.

Methods Consecutive patients admitted to gastroenterology with an established diagnosis of IBD were asked to complete a questionnaire exploring their point of access, admission process, waiting times and treatment during admission before their discharge from hospital

Results 50 patients were recruited (30 UC, 19 CD, 1 indeterminate) First point of access after admission was recommended included 30 pts arriving at A&E, 11 via medical admission unit, 7 directly via gastroenterology services and 2 to other departments.

Other pathways once admitted involved 14 pts transferring to 2-wards and 29 pts to 3 wards.

32 patients were commenced Intravenous steroids in first 24 hours, 8 patients waited longer than 24 hours. 8 patients did not commence any treatment relating to an acute exacerbation of IBD

Conclusions Patients were admitted to a number of different wards via a variety of routes. Many were waiting for long periods of time & some patients did not require hospital admission. As a result of this evaluation we have established a 'Hot Clinic'

PTU-093 EVALUATING A NURSE LED INFLAMMATORY BOWEL DISEASE HOT CLINIC

Sharon Gethins*, Sanjeev Pattni, Richard Robinson, Tracey Duckett, Jodie Walton, Kelly Hiatt. *University Hospitals Of Leicester, Leicester, UK*

10.1136/gutjnl-2019-BSGAbstracts.452

Introduction Inflammatory Bowel Disease (IBD) can be an unpredictable condition with relapses requiring escalation of therapy and possible admission to hospital. The IBD Standards of Care recommend that patients with Crohn's disease and Ulcerative colitis have rapid access to specialist doctors and