PTU-102 MODERN MANAGEMENT OF PRIMARY BILIARY CHOLANGITIS: MULTIDISCIPLINARY TEAM DECISION-MAKING USING A HUB AND SPOKE MODEL

Miss Sital Shah, Deepak Joshi, Prof Michael Heneghan. *Institute of Liver Studies, Kings College Hospital NHS Foundation Trust, London, UK*

10.1136/gutjnl-2019-BSGAbstracts.461

Introduction In April 2017, NHS England (NHSE) commissioned the use of obeticholic acid as a licensed treatment option for primary biliary cholangitis (PBC), an autoimmune liver disease which causes progressive destruction in interlobular bile ducts leading to chronic liver disease. As per commissioning requirements, access is limited via specialist hospitals through referral to a dedicated hepatology multidisciplinary team (MDT). As one of the large tertiary referral centres chosen as a referral site, we took the approach of establishing a hub and spoke model to enable access to specialist care without the need for patients to be seen directly at the referral site.

Methods A PBC specific MDT with a quorum consisting of two Consultant Hepatologists and a Specialist Hepatology Pharmacist was established at the hub site. Hospitals in the surrounding area which were considered spoke sites were identified and contacted by the MDT to inform them of the process of making referrals. A training event was organised inviting all spoke hospitals to discuss the pathway and address their needs as referrers in addition to providing an update on

current guidelines and therapies for the management of PBC. Figure 1 shows the simple referral pathway established. A telephone and email helpline was made available to patients and referring clinicians in the event of any adverse effects or if further advice was required.

Results In a 14-month period, 77 patients were referred to the PBC MDT with 38/77 (49%) of patients being referred from spoke sites. 46/77 (60%) of patients were commenced on obeticholic acid, 26/77 (34%) were commenced on bezafibrate (unlicensed), 3/77 (4%) patients were recruited into a clinical trial and 2/77 (2%) patients were referred for transplant assessment.

Conclusions This demonstrates that the management of PBC is achievable through the development of hub and spoke pathways with key stakeholder input. It ensures equity of access to care and linkage to specialist services for the long term management of liver health.

PTU-103 HOME-DELIVERED INFlixIMAB INFUSION PROGRAMME IN IBD PATIENTS: SAFETY EVALUATION AND PATIENT SATISFACTION

Vivek Goodoory, Fahad Ali Shaikh*, Joanna McConnell, Richard Shenderoy. *Airedale NHS Foundation Trust, Keighley, UK*

10.1136/gutjnl-2019-BSGAbstracts.462

Abstract PTU-102 Figure 1 Referral pathway

Introduction Treatment with infliximab for patients with Inflammatory Bowel Disease (IBD) in the UK consists of intravenous infusions usually delivered in hospital via a nurse-led service. Several studies have proven the safety of infliximab infusions at home which also eases the capacity for hospital infusions. However, the uptake in clinical practice has been slow in the UK. We aim to evaluate the safety and patient satisfaction of home infliximab infusions in a district general hospital 4 years after its introduction.

Methods This is a retrospective audit of all IBD patients enrolled in a home infliximab infusion programme from July 2014 to July 2018. Data were collected from the electronic database and case notes. Data collected included serious adverse reactions requiring hospital admission and number of times home infusions were put on hold/stopped because of safety concerns. Patients currently on the home infliximab infusion programme were interviewed by telephone by 2 Gastroenterology specialist trainees. Satisfaction rate (out of 10) were collected for adequate communication, delivery times, customer service, driver assistance/attitude, nurse support service, clinical waste collection and overall satisfaction.

Results A total of 41 patients were included in the analysis (3 excluded due to insufficient follow up data): median age was 42 years, 19 (46.3%) were women, 9 (22%) had ulcerative colitis and 32 (78%) had crohn's disease. Three hundred and seventy three (373) infliximab infusions were given at home: there were no deaths and no adverse reactions requiring hospital admission. There were 3 (0.8%) instances where home infliximab infusions were put on hold or stopped as shown in table 1. Patients were given a median number of 7 doses of infliximab in hospital before moving to the home infliximab infusion. The median follow up time on home infliximab was 14 months and the median number of doses given at home was 7.

Abstract PTU-103 Table 1: Patients who had their home infliximab on hold, rationale for pausing and follow up

Patient	Number of infusions in hospital	Number of infusions at home prior to holding	Reason home infliximab on hold	Follow up
1	8	14	Skin rash – managed in the community	A further dose was given in hospital. Infliximab completely stopped following similar skin rash
2	21	32	Low blood pressure following infliximab infusion	Next infliximab dose given in hospital as precaution
3	12	19	Patient became pregnant	Home infliximab restarted after pregnancy

Eighteen (69.2%) out of 26 patients on home infliximab in July 2018 responded to a telephone interview. Mean and median satisfaction rates were 9.7 and 10 (out of 10).

Conclusion A home infliximab infusion programme for patients with IBD is safe with all adverse reactions being minor and managed in the community. Patient satisfaction rate is high.

PTU-104 NO SURVEILLANCE OR 5-YEAR COLONOSCOPY? THE COST SAVINGS OF DISCONTINUING SURVEILLANCE FOR LOW RISK ADENOMAS

Benjamin Shandro*, Vincent Chang, Jai Mathur, Parker O'Neill, Christopher Groves, Gareth Sadler, Andrew Poullis. *St George's University Hospitals NHS Foundation Trust, London, UK*

10.1136/gutjnl-2019-BSGAbstracts.463

Introduction The benefit of colonoscopy surveillance for low risk adenomas (LRAs) is unclear. The BSG currently recommends either no surveillance or 5-year colonoscopy. It has recently been shown that following removal of LRAs, patients are not at increased risk of colorectal cancer compared to the general population. This suggests colonoscopy surveillance in these patients may not be necessary. In particular, patients aged 6–4 years when surveillance is due are eligible for biennial stool testing in the national bowel cancer screening programme (BCSP), which provides a potential alternative for follow up. We aimed to estimate the cost savings and endoscopy capacity that could be generated by discontinuing colonoscopy surveillance for LRAs.

Methods We conducted a retrospective endoscopy database analysis of patients for whom 5-year colonoscopy surveillance had been requested for LRAs between 2013 and 2018 at a London teaching hospital. Patients with inflammatory bowel disease, previous colorectal cancer or Lynch syndrome were excluded. The age at which colonoscopy surveillance was due was calculated. We calculated the annual cost savings and endoscopy capacity that could be generated for our trust by ceasing colonoscopy surveillance for LRAs in patients aged 6–4 years and in all patients, using the 2018 NHS tariff for diagnostic colonoscopy of £406.

Results 1035 patients were booked for colonoscopy surveillance for LRAs during the 5-year study period. 51.7% were male. The mean age at which colonoscopy surveillance was due was 63.5 years (SD 12.6). Discontinuing colonoscopy surveillance in patients aged 6–4 years with LRAs would save our trust £34,997 per year and generate an additional 87 colonoscopy appointments per year. Discontinuing colonoscopy surveillance in all patients with LRAs would save our trust £84,042 per year and generate an additional 207 colonoscopy appointments per year.

Abstract PTU-104 Table 1 Annual cost savings and capacity generated by ceasing colonoscopy surveillance in patients with LRAs

Model	Patients offered colonoscopy surveillance over 5 years (n (%))	Cost of colonoscopy surveillance over 5 years	Cost saving per year	Colonoscopy capacity generated per year (n)
Colonoscopy surveillance for LRAs	1035 (100)	£420,210	£0	0
No colonoscopy surveillance for LRAs if aged 6–4 years	604 (58)	£245,224	£34,997	87
No colonoscopy surveillance for LRAs	0 (0)	£0	£84,042	207