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P351 CONSULTANT RECRUITMENT AND RETENTION – WHAT APPLICANTS SEEK IN A POST. A REGIONAL SURVEY

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10.1136/gutjnl-2020-bsgcampus.425

Introduction Nearly half of advertised gastroenterology and hepatology posts remain unfilled (Royal College of Physicians, 2019). It is therefore important to identify key positive and negative factors trainees consider when applying for a consultant job to construct appealing and resilient services, particularly for hard-to-fill posts.

Methods An online questionnaire was sent to south west gastroenterology trainees and to newly-appointed consultants to rate the importance of each factor when considering a consultant job.

Results Our 36 (21 male, 15 female) respondents from a possible of 44 (82%), worked across all training grades and mostly full time (89%). The majority felt geography was very important (n=22, 62%) and personal experience of working in the hospital important (n=19, 53%). Enticing factors to apply included availability of specialist nurses and protected time to develop training and subspecialty.

Financial inducements were less important. General medical on calls was the only factor which actively discouraged job application (n=23, 64%) and links to academic institutions were deemed less important in over half of respondents. 78% of trainees would consider applying for a consultant job outside their training deanery; the influence of the availability to work less than full was inconsistent.

Conclusion This regional survey provides an important insight into applicant views to assist with consultant recruitment and retention. Removing general medicine from gastroenterology, enabling time to develop clinical and managerial skills and availability of specialist nurses are key attractive factors.

Whilst geographical location cannot be changed, personal experience was rated a strong factor influencing job considerations; rotating senior trainees in peripheral hospitals provides an opportunity to negotiate an appealing job plan not previously considered as well as benefiting departments struggling to recruit.

For trainees in the south west financial enticements and academic links were not considered important considerations. Working less than full time (LTFT) was of varying importance but the LTFT workforce is likely to increase in the future as more female trainees obtain substantive consultant posts (Rutter, C, 2018). With the change to pension age rules, consultants may now plan early retirement having an additional impact on the consultant workforce shortage. As salary is less important, offering the option for flexibility when advertising consultant jobs should encourage more applications and hopefully retain the existing consultant workforce as more desirable roles become available.

This has many unique challenges (particularly geographical spread and population density). As such these findings may not be applicable to large conurbations where further surveys are warranted.

P352 CREATION OF A NEW GUIDELINE FOR THE MONITORING OF LIVER FIBROSIS IN PSORIATICS ON METHOTREXATE

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10.1136/gutjnl-2020-bsgcampus.426

Introduction Methotrexate is extensively used in dermatology and rheumatology and, to a lesser extent, for inflammatory bowel disease. There is a well-recognised association of methotrexate use and the development of liver fibrosis and cirrhosis. Despite this there is surprising inconsistency in guidelines and in practice for the monitoring for liver-related complications. Patients with psoriasis appear to be at the highest risk of developing liver fibrosis and so the British Association of Dermatology (BAD) stipulates the use of serum procollagen III aminoterminal peptide (PIIINP) three-monthly to monitor for this. However, this test is not used elsewhere as an individual marker of liver fibrosis.

Methods We obtained all PIIINP levels that were raised during the year of 2019 at the Whittington Hospital and reviewed their onward referral and outcomes.

We then performed a literature search on methotrexate therapy and liver toxicity in patients with psoriasis. Using this we created a new evidence-based guidance for the monitoring of liver fibrosis in psoriatic patients commencing methotrexate.

Results Eight patients fulfilled BAD criteria for onward referral to gastroenterology based on their PIIINP levels, of which six were referred and seen. Interestingly, gastroenterologists are generally unaware of the significance and meaning of PIIINP and generally go on to perform further non-invasive tests of liver fibrosis, notably a fibroscan.

Based on the literature review and findings, we generated an alternative guideline on the monitoring of liver fibrosis in psoriatic patients on methotrexate. The guidance advises fibroscan for all patients at baseline and then stratifies patients into high- and low-risk categories based on baseline BMI, alcohol intake and diabetes. Fibroscan interval is based on risk category and baseline level ranging from 1 to 3 years. Those with liver stiffness greater than 9.5 kPa are referred for onward assessment. If unable to obtain fibroscan measurements, PIIINP would be used as before.

Conclusions The incidence of fibrosis secondary the methotrexate toxicity is rare and the greater incidence in psoriatics likely relates to its association with known risk factors for non-alcoholic fatty liver disease and alcohol consumption. PIIINP is a poor predictor of fibrosis in the subset of patients with psoriatic arthritis and is not extensively used outside dermatology, even amongst gastroenterologists. Fibroscan has a good negative predictive value for significant fibrosis and so is a suitable screening test and is in line with current gastroenterology practice

P353 COST EFFECTIVENESS OF TAKING NON-TARGETED ENDOSCOPIC BIOPSIES- CAN WE SAVE TIME AND MONEY?

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10.1136/gutjnl-2020-bsgcampus.427

Introduction Numerous studies have questioned the value of taking biopsies in endoscopic macroscopically normal mucosa. Inappropriate biopsies increase financial and time strains on NHS endoscopy and pathology services. Taking a biopsy adds to each procedure a cost of £56 for gastroscopy and £66 for colonoscopy. With 4.5% yearly increase in demand for histopathology services and only 1.2–3% per year increase recruitment of cellular pathologists, number of patients waiting longer than 6 weeks for diagnostic results has increased by 17% per year since 2010–11.

Methods We did a retrospective study of diagnostic gastroscopies and colonoscopies performed across 3 district-general hospitals (January–November 2018) in United Lincolnshire Hospitals NHS Trust. Endoscopic reports were examined for age, sex, indication, endoscopic diagnosis, biopsies taken (yes/no), and operator (gastroenterologist/surgeon/nurse endoscopists {NE}). We classified 'biopsy not indicated' when mucosa was described as 'normal' for indications of anaemia, rectal bleeding, weight-loss in colonoscopies, and dyspepsia, vomiting and abdominal pain in gastroscopies.

Results A total of 326 gastroscopies and 355 colonoscopies were included. 170 procedures fulfilled the 'biopsy not indicated' criterion, of which 59% had multiple biopsies (at least 5 specimens) taken. Biopsy rates among gastroenterologists, surgeons, and NEs in 'biopsy not indicated' were 53% (39/73), 60% (42/70) and 70% (19/27) respectively. Using Chi-square, there was no statistically significant difference between various groups: surgeons and NEs ($p = 0.34$), surgeons and gastroenterologists ($p = 0.42$), and gastroenterologists and NEs ($p = 0.12$).

Conclusions Our study showed that a significant number of biopsies are performed without good indication. Further, no significant inter-operator variability was seen. Both British Society of Gastroenterology and National Institute for Health and Care Excellence have published guidance on when biopsy is indicated, but there are few high-level recommendations on when not to biopsy. Taking a biopsy cost of £103 a potential of £ 10330 could have been saved during our study period. Findings from our study mandate development of such guidance, followed by training of all endoscopists and UK-wide audit of local practice to ensure compliance with guidelines. The implementation of such strategies has been proven effective at a local level, and if adopted nationally can significantly optimise financial burden on the NHS and reduce waiting times.

P354 A MULTI-CENTRE AUDIT OF LOWER GASTROINTESTINAL BLEEDING MANAGEMENT

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10.1136/gutjnl-2020-bsgcampus.428

Introduction Two national reviews identified unwanted variation in the care of patients with gastrointestinal haemorrhage. British Society of Gastroenterology (BSG) acute lower gastrointestinal bleeding (LGIB) guidelines define a specific management approach including risk stratification, investigation and

intervention for patients presenting with LGIB. Guideline adoption, impact on 'real-world' clinical outcomes and resource implications are not known. The Mersey Gastroenterology Network conducted a region-wide, multi-centre, pilot audit of LGIB management in relation to BSG guidance to assess this.

Methods Patients aged ≥ 16 years presenting with LGIB to five hospital trusts from June 1st–July 1st 2019 were included. Data on presentation, management and outcomes of patients were recorded. These were audited against BSG guidelines.

Results 104 patients were included. Mean age at presentation was 60 years (range 23–96). A Shock Index (SI) > 1 was rare (7.7%), with a mean SI of 0.69 on presentation. 67% of patients haemodynamically unstable despite initial resuscitation underwent computed tomogram angiography (CTA). 21 patients (20.2%) had a low risk Oakland Score (OS) (≤ 8 points); 29% were admitted whilst 71% were discharged for outpatient management. 75 patients (78.9%) had a high-risk OS (> 8 points); 61% were admitted and 39% were discharged. In patients discharged with a high-risk OS (median 11), 6.9% were readmitted within 30 days. Admitted patients underwent CTA (10.2%), colonoscopy (8.5%), flexible sigmoidoscopy (3.4%) or OGD (22%) as initial investigation. 55.9% were observed without diagnostic investigations for an average of 3 days before discharge. Rebleeding within 7 days, readmission within 30 days and inpatient mortality was 9.3%, 15.8% and 3.4% respectively. The median length of admission was 3 days (range 0–60). 38.5% of patients were managed in line with BSG guidance. The most common deviation was patients with an OS > 8 being monitored without investigation during admission (31.7%).

Conclusions LGIB management does not follow current guidelines. We report low mortality and readmission rates, even in patients discharged with a 'high-risk' OS. Admitted patients rarely receive an urgent inpatient colonoscopy. We aim to collect data over an extended period to provide further insights and analyse economic and resource feasibility of guideline adherence.

P355 DESIGN AND IMPLEMENTATION OF THE FIRST ONE-STOP MULTIDISCIPLINARY CLINIC FOR LYNCH SYNDROME IN THE UK

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10.1136/gutjnl-2020-bsgcampus.429

Introduction The clinical benefit of a multidisciplinary clinic (MDC) model has been well documented for a variety of medical conditions. We designed and implemented a novel MDC for Lynch syndrome (LS) patients, which aims to improve treatment outcomes, participation in research trials, and patient satisfaction.

Methods From January 2019, LS patients in our region were invited to attend a bimonthly MDC offering gene-specific evidence-based cancer risk management. Patients could choose to see the gastroenterology, colorectal, gynaecology, medical oncology, research, and clinical psychology teams. Clinical outcomes and patient satisfaction were evaluated over 12 months.

Results Thirty-eight LS patients were seen (8 *MLH1*, 18 *MSH2*, 8 *MSH6*, 4 *PMS2*); mean age was 46y (range: 20–