96.92 kg for OGD (21.85 g per OGD); 35.30 kg for sigmoidoscopy (15.68 g per sigmoidoscopy); and 159.38 kg for colonoscopy (50.84 g per colonoscopy). In 1 year, the total plastic generated from sterile water bottles alone for these procedures was 291.6 kg. The total cost for sterile water was £3588.80 (£1192.80 for OGD, £434.40 for sigmoidoscopy and £1961.60 for colonoscopy).

Conclusion We conclude that significantly large volumes of sterile water and single use plastic are being used in endoscopy. This practice is not only costly but also has a detrimental impact on the environment due to the large amount of plastic generated. Reduction of single use plastic needs to be a priority for a greener and more sustainable practice of endoscopy.

P360

PILOT INTRODUCTION OF A TRIAGE SYSTEM REDUCES THE WORKLOAD OF THE HPB MDT

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Introduction The East Midlands Hepatobiliary Multidisciplinary Team (HPB MDT) serves a population of 2.4 million people. The high volume of referrals and increasing complexity of cases has consistently led to significant time constraint for case discussion and potential delay in timely delivery of care. Therefore, a triage system was introduced to identify cases where a full discussion was unnecessary or premature. The aim was to improve the operation of MDT meetings (MDTM) and deliver a streamlined, transparent pathway for all patients.

Methods A triage system was piloted in two of four regional trusts from January 2019. The triage team included two hepatologists, a HPB surgeon, a specialist nurse and an administrator. In line with national guidelines and local policies, triage pathways were developed for cases for which discussion in the main MDTM would not result in additional benefit. These include (1) registration only (2) probable benign pancreatic/liver lesions under surveillance (3) HCC on established treatment (4) advanced HPB cancers on established chemotherapy (5) patients with inadequate investigations (6) post-operative histology. Pathways were reviewed and approved at relevant governance meetings. All referrals were reviewed by the triage team 48 hours prior to the MDTM and two lists were created; one for triage and one for full discussion. Outcomes for those on the triage list were given after review and approval from the radiologist and/or histopathologist. For the first 4 weeks of implementation, all triage decisions were also reviewed at the MDTM. Data on the triage process were prospectively collected from January to December 2019. These were compared with the number of patients who were discussed in the previous 4 years. All statistical analyses were performed using GraphPad Prism 8 (San Diego, CA).

Results A total 2,686 referrals were received in 2019, which was comparable to the previous 4 years ($p=0.11$, figure 1). Adoption of the triage system led to a mean reduction of 37 patients/month to the MDTM ($p<0.0001$, figure 1). This was a 15% reduction in workload for the overall MDT and a 25% reduction for the 2 trusts that participated. All triaged patients were given a recommendation for further management

within the same time period for full MDT discussion. There were no reports of harm or complaints attributable to the triage system during this period.

Conclusions The above results confirm that streamlining of the HPB MDT pathway is feasible and significantly reduces the numbers discussed in the full MDTM without compromising patient care.

P361

THE RELIABILITY OF 'COFFEE-GROUND' VOMITING AS AN INDICATOR OF ACTIVE UGIB: A TERTIARY CENTRE EXPERIENCE

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Introduction Acute Upper GI Bleeds (UGIB) are a common medical emergency and account for significant morbidity and mortality. 'Coffee-ground' vomiting is considered indicative of UGIB however its reliability as an indicator of active bleeding is contentious. OGD is the current gold standard in the diagnosis and management of UGIB however UGI capsule endoscopy is an emerging alternative which can rapidly screen for bleeding and has benefits over OGD in terms of invasiveness, patient tolerance, rapid deployment anywhere and thus reduced hospital admission rates and ultimately cost-effectiveness. The aim of this study was to establish whether coffee-ground vomiting is a reliable indicator of active UGIB.

Methods Electronic referrals for OGD, which contained the phrase 'coffee-ground vomiting', were analysed and endoscopy reports assessed to identify whether active UGIB was identified.

Results During a 12-month period; 552 electronic endoscopy referrals for UGIB were submitted. 62 referrals contained the specific phrase 'coffee-ground vomiting'; 9 patients were excluded. 33/53 referrals came from inpatient medical wards. 35 patients were male, mean age at time of referral was 67.5 years (22.0 – 90.0). Mean Glasgow Blatchford Score at referral was 7.4 (1.0 – 15.0). Mean time between referral and endoscopy was 1.3 days (0.0 – 12.0).

The most common endoscopic diagnoses were oesophagitis (16/53 cases) and gastritis (9/53 cases). OGD findings were normal in 10 cases. Active bleeding was identified in 6 patients and in 2 patients a visible vessel was visualised without evidence of active bleeding at endoscopy. 4 patients required endotherapy namely injection and clipping, 1 patient required variceal banding. All 6 patients with confirmed active bleeding on endoscopy had melaena on presentation.

Mean length of stay (LOS) was 8 days (1.0 – 203.0) and in 1 case a repeat OGD was required during the same admission.

Conclusions The results of this study demonstrate that only a minority of OGDs performed for the indication of 'coffee-ground' vomiting demonstrated active UGIB. In addition, a significant proportion of the cohort had a normal study. No patients with coffee ground vomiting without melaena had active UGIB and none of these patients required endotherapy.

This study could be used to support the proposal that patients with coffee-ground vomitus without other

corroborating evidence of UGIB are very unlikely to have active bleeding and/or the need for endoscopic haemostasis. These patients could have an UGI capsule endoscopy in the emergency department as opposed to hospital admission and subsequent wait for an inpatient OGD. This could consequently have significant implications on admission rates, LOS and hospital associated morbidity.

P362 DEVELOPMENT OF THE FIRST UK LICENCED FAECAL MICROBIOTA TRANSPLANT SERVICE: RESULTS OF FIRST YEAR'S ACTIVITY

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Introduction The use of Faecal Microbiota Transplant (FMT) has become established practice for the treatment of recurrent or refractory *Clostridioides difficile* infection (CDI). It involves the transplant of minimally processed donor faecal material into a recipient's GI tract. Regulatory change in 2015 saw FMT classed as a medicinal product in The Human Medicines Regulations. As recognised by joint British Society of Gastroenterology and Healthcare Infection Society guidelines, these regulatory requirements are more readily fulfilled by a specialist centre, utilising a supply and satellite model - akin to that adopted by the Microbiome Treatment Centre (MTC). The MTC, supplies FMT on a named-patient basis under a Manufacturer's Specials' (MS) licence. FMT is supplied under the 2019–2020 NHS England Innovation and technology payment tariff, zero-cost model.

Methods The MTC strictly screens donors. Dedicated laboratory facilities are used for FMT production, minimising the risk of cross-contamination and allowing standardisation of the production process. FMT is stored frozen, allowing for multiple samples to be obtained immediately after donor screening. A numbering system is used in conjunction with a treatment directory to track FMT preparations. A multidisciplinary team approach is adopted, with screening, production and deployment overseen by a clinical gastroenterologist, microbiologist, service and production managers. Each FMT request is assessed for its clinical indication and then discussed with the requesting clinician.

Abstract P362 Figure 1 Cumulative FMTs (by month)

Results From August 2018-January 2020, 181 FMT treatments have been given to 159 patients in 61 hospitals around the UK for recurrent or refractory CDI (Abstract P362 figure 1). 139 of these patients received a single FMT treatment with 20 patients receiving further transplants. Clinical follow up data has been received for 79% (n=110) of patients receiving a single FMT treatment. There has been an 81% (n=89) rate of reported resolution of CDI at 7 days post-transplant.

Of the 20 patients requiring more than 1 FMT, 4 had showed resolution of symptoms at 7 days post both first and second transplant, suggesting re-infection. All requested FMTs have been supplied to the clinical sites for the requested treatment date (25% were supplied in under 24 hours, 34% within 24–48 hours and 40% in over 48 hours.)

Conclusions The further development of the UK's first FMT service has greatly improved NHS access to this novel technology, with 45 NHS trusts using the service in the past year, compared to 21 the year previously. FMT material is supplied expediently, with the majority arriving with the requesting clinician in under 48 hours.

P363 STARTING AZATHIOPRINE IN IBD: PRESCRIBE A THERAPEUTIC DOSE OR START LOW AND INCREASE SLOWLY?

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Introduction Azathioprine is frequently prescribed for the management of inflammatory bowel disease (IBD), however there is considerable variation in how it is initiated. It remains common practice to start patients on low dose Azathioprine and gradually increase the dose, with the belief that this approach will improve drug tolerance. However, this process can take several weeks or months to reach a therapeutic drug level, requiring multiple blood tests and patient contacts.

Since April 2018, patients attending our IBD clinic who require Azathioprine, have been started directly on to a therapeutic 2 mg/kg dose. Outcomes from this 'therapeutic dose group' of patients (TDG), in terms of drug tolerability and safety, are compared to those from patients that started Azathioprine prior to April 2018, who were started on a low dose and increased gradually (LDG).

Methods In this single-centre, retrospective, observational study, adult IBD patients starting on Azathioprine between March 2016 and November 2019 were identified using pharmacy records. Patients with low thiopurine methyltransferase (TPMT) level, and patients who had taken thiopurine medication previously were excluded from the study.

The proportion of patients successfully established on Azathioprine was compared between the two groups, with a 'success' defined as continuing a therapeutic dose of medication beyond three months. Reasons for stopping Azathioprine prior to this were recorded.

Results The proportion of patients successfully established on Azathioprine was similar in both groups, with 54% in the LDG (n=63) compared to 66% in the TDG (n=29). There