cholangitis was observed in 14.9% of WE group and 12.2% of WD group ($p=0.54$). Intensive care admissions were observed in 5.7% of the WE group and 3.2% in the WD group ($p=0.32$). 88.3% ($n=166$) of patients in the WD group and 86.4% ($n=76$) of patients in the WE group underwent endoscopic retrograde cholangiopancreatography (ERCP) during their admission; with the remaining patients deemed unsuitable to undergo ERCP. 4 patients underwent emergency out of hours ERCP (2 patients from each group). There was no difference between median time from admission to ERCP (WD 5.4 days, WE 4.9 days; $p=0.78$) or length of stay (WD 8.1 days vs WE 8.2 days, $p=0.98$). The 30-day all-cause mortality rate was 3.7% in the WD group and 6.9% in the WE group ($p=0.25$) and in those who underwent ERCP: 2.4% in the WD group and 3.9% in the WE group ($p=0.51$). 83.3% of WE deaths and 71.4% of WD deaths were of patients who had cholangitis of malignant aetiology.

Conclusions Our data did not demonstrate a clear 'weekend effect' in patients admitted to a tertiary hepatobiliary centre with acute cholangitis, although there was a trend towards increased intensive care admissions and 30-day mortality amongst patients admitted over the weekend. Further studies on a regional or national level may be warranted.

P374 SUB-OPTIMAL VACCINATION UPTAKE IN HIGH-RISK PATIENTS WITH INFLAMMATORY BOWEL DISEASE

Parker O'Neill*, Benjamin Shandro, Andrew Poullis. *St. George's, University Of London, London, UK*

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Introduction According to the current BSG guideline on the management of inflammatory bowel disease (IBD) in adults, all patients with IBD taking systemic immunosuppressants should be vaccinated with the seasonal influenza and pneumococcal vaccines to reduce the risk of infection. We audited vaccination uptake in patients with IBD attending gastroenterology outpatient clinics at our trust and explored the perceived barriers to vaccination.

Methods A voluntary, anonymous, multiple-choice questionnaire was offered to patients with IBD attending gastroenterology outpatient clinics at a London hospital from November 2019 to February 2020. The questionnaire captured data on vaccination history, perceived barriers to vaccination, and whether any healthcare professionals had discussed vaccination with them. Convenience sampling was used, and informed consent was gained from all participants. Descriptive statistics were used to present the results.

Results 116 patients completed the questionnaire; 46.6% male; mean age 47 years. 50 patients (43.1%) had Crohn's disease, 46 (39.7%) had ulcerative colitis, and 20 patients (17.2%) were unsure of their IBD subtype. 88 patients (75.9%) were identified as high-risk; 53 due to current immunosuppression, and 35 due to historic corticosteroid use alone. Azathioprine was the most commonly prescribed immunosuppressant, with current use reported by 41 patients (35.3%). 19 patients (16.4%) were taking biological therapy.

54 high-risk patients (61.4%) had received their seasonal influenza vaccine. Of the 34 unvaccinated patients, 11 (32.4%) were unaware vaccination was recommended, 11 (32.4%) stated that the vaccine hadn't been offered to them,

12 (35.3%) were concerned about potential side effects, and 4 patients (11.8%) didn't believe vaccinations were effective. 8 unvaccinated patients (23.5%) planned on being vaccinated in the near future. Uptake of the pneumococcal vaccination was even lower, with 18 patients (20.5%) reporting previous vaccination.

Only 16 patients (13.8%) could recall their vaccination history being checked when they were diagnosed with IBD. 48 patients (41.4%) recalled ever previously discussing the benefits of vaccination with a healthcare professional.

Conclusions Vaccination uptake is sub-optimal in the immunosuppressed IBD population. High-risk patients with IBD may be unaware that vaccination is recommended for them or be unaware of its benefits. Healthcare professionals, including gastroenterologists, must be more proactive in discussing vaccination with patients.

P375 PATIENT PERSPECTIVES ON THE USE OF SOCIAL MEDIA IN THE MANAGEMENT OF INFLAMMATORY BOWEL DISEASE

Parker O'Neill*, Benjamin Shandro, Andrew Poullis. *St. George's, University Of London, London, UK*

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Introduction Inflammatory bowel disease (IBD) is a chronic condition. The fluctuating clinical course and regular monitoring disrupts the work and family lives of patients living with IBD. Integration of social media into disease management could provide an opportunity to increase treatment efficiency and save patients' time. We carried out a survey of IBD patients' current social media usage, and their perspective on the use of social media in the management of IBD.

Methods A voluntary, anonymous, multiple-choice questionnaire was offered to patients with IBD attending gastroenterology outpatient clinics at a London hospital from November 2019 to February 2020. The questionnaire captured data on current social media usage and the patient perspective on the use of social media for formal healthcare delivery. Convenience sampling was used, and informed consent was gained from all participants. Descriptive statistics were used to present the results.

Results 112 patients completed the questionnaire; 44.6% male; mean age 47 years. 50 patients (44.6%) had Crohn's disease, 46 (41.1%) had ulcerative colitis, and 16 patients (14.3%) were unsure of their IBD subtype. 110 patients (98.2%) had access to a device that could access the internet, with 74 patients (66.7%) able to access the internet anywhere via smartphone. 93 patients (83.0%) used social media. Facebook and Instagram were the most popular applications, with 81 (72.3%) and 58 users (51.7%), respectively. However, only 32 (28.6%) patients used social media for their IBD. Of these, 19 patients (59.4%) used it for general information about their condition, 16 (50%) used it for support and coping strategies, 15 (46.9%) used it to get illness advice, 9 (28.1%) used it to relieve illness anxiety, and 2 (6.3%) used it to befriend other individuals with IBD.

81 patients (72.3%) stated that they would like healthcare professionals to interact with them via social media. 55 patients (67.9%) thought that direct, one-to-one, contact with

a gastroenterologist via social media would be desirable, and 46 patients (56.8%) wanted a gastroenterologist to answer patient questions in a dedicated social media group. Only a small number of patients had concerns regarding the use of social media in healthcare. The most commonly reported concerns were that their medical condition would not be effectively treated (9.8%), or that the quality of care provided would be inadequate (8.9%).

Conclusion The majority of IBD patients are active on social media, and most would welcome the integration of social media into the management of their IBD. Some platforms have already begun offering these services. Further research is required to investigate the optimal method to integrate social media into the delivery of IBD services.

P376 DEVELOPING A CONSTIPATION SERVICE – WHAT IS THE REAL COST OF CONSTIPATION?

Sarah O'Neill*, Nicholas Wilson, Alexandra Kent, Bu'Hussain Hayee. *King's College Hospital, London, UK*

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Introduction Constipation is a common complaint in the UK, generating a significant burden of A&E attendances and accounting for £71 million in unplanned admission in 2017/18. This study aimed to establish the cost and wider impact of these admissions on hospital services, to develop a streamlined constipation service at the Trust.

Methods We interrogated 11 years of retrospective data (2008–2018), outlining every admission at a teaching hospital coded as constipation (k59.0). Key criteria identified included: length of stay, age at attendance, gender, primary and secondary diagnoses, and medical specialty providing care. Analyses of these criteria were carried out to establish basic demographic data, evaluate changing epidemiological features over time, and create a cost estimate of these admissions to the Trust.

Results There were 6111 patient admissions with constipation as a diagnosis in the study period, with a 463% increase in admissions during this time. Patients were admitted under 28 different specialties ranging from General Medicine to Psychiatry.

2538 patients accounted for 3055 admissions with constipation as the primary diagnosis, with a mean age 57 years and females accounting for 57%. Mean age has increased from 57 years to 70 years during the study period. 301 patients had >1 admission (range 1–21). Mean length of hospital stay (LOS) was 3 days (median: 0.9, range 0–80), although the mean has decreased from a 6 days in 2008 to 1 day in 2018.

Only 2% of admissions had an identifiable cause and opioid use was the commonest precipitant. Admissions with functional constipation is reducing, accounted for 1% of all admissions. 25% of all admissions had potential adverse sequelae resulting from constipation, ranging from benign haemorrhoids to perforated diverticular disease.

At our hospital the total cost of hospital bed nights alone (excluding treatment costs) for primary constipation was £3,665,240 over 11 years, rising from £233,120 in 2008 to £397,040 in 2018.

Conclusion The number of admissions with constipation is increasing, with a significant number of recurrent attenders and an associated increase in rudimentary costs. Almost

every hospital-based specialty had inpatients with constipation over the ten-year period. There are obvious precipitants and adverse sequelae. This study has established the cost justification of a constipation pathway at our hospital, as well as providing data to monitor the intervention of a constipation clinical nurse specialist. Using these services to provide early specialist management is likely to permit a reduction in cost and duration of admissions within all hospital specialties.

P377 IMPACT OF THE FAECAL IMMUNOCHEMISTRY TEST (FIT) ON BOWEL CANCER SCREENING (BCS) RESOURCES

Stavroula Pelitari*, Abhirami Gautham, Pritesh Mistry, Siddhartha Mohan, Matthew Brookes, Brian McKaig, Andrew Veitch, Aravinth Muruganathan. *The Royal Wolverhampton NHS Trust, Wolverhampton, UK*

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Introduction From July 2019, FIT replaced Faecal Occult Blood Test (FOBT) as the BCSP screening tool for individuals aged 60 to 75. As FIT detects and quantifies human haemoglobin in stool, changes in service demands were expected due to increased sensitivity. Additionally, pilot testing noted increased screening uptake from 59.3% to 66.4%.¹ The extent of the change upon service demand has not been assessed in the full BCSP.

We aimed to assess the impact of this change on BCS associated resources at our screening centre.

Methods Data was analysed from all patients attending appointments with a Specialist Screening Practitioner (SSP) after either a positive FOBT (March to May 2019) or FIT (September to November 2019) test. The June to August 2019 period was excluded due to a cross over period between the 2 kits. Endoscopy, radiology and surgical procedures as well as histology and SSP time were recorded. 45' slots of SSP time were allocated for each of initial consultations, attendance at colonoscopy and colorectal multidisciplinary team meeting (if applicable); 20' slots for flexible sigmoidoscopy and EMR consent. Subsequent follow up telephone or clinic consultations were allocated 10'. Statistical testing was undertaken with an unpaired t-test.

Results 164 patients attended in the FOBT group and 216 patients in FIT- a increase of 32% (n=52) in patients with positive tests attending for appointments.

Comparing the 3 month periods, FIT testing required 63 more endoscopic procedures (212 vs 149 colonoscopies and 4 vs. 7 flexible sigmoidoscopies). There were 102 hours of additional SSP time required and a 112% increase in the endoscopic polyp/biopsy samples with 190 extra specimens. There were significantly more polyps found within the FIT group (n=337 vs. 154, p=0.004). Total numbers of radiological investigations remained similar (31 FIT vs. 28 FOBT). Patients with malignancy requiring surgery (13 vs. 6) or palliative oncological treatment (2 vs. 1) were higher in the FIT group thereby doubling surgery and oncology resource needed. Estimation of financial impact is underway.

Conclusions The change to FIT testing within our service has led to notable increases in service demand on SSP time, endoscopy procedures and histopathology services. There has also been a doubling of cancers resulting in impact on surgery and oncology resource. Analysis of this impact aids workforce and service planning in NHS sites delivering BCS.