The poor response rate is a concern and steps to remedy this may include follow up telephone consultations, patient education and encouraging patients to access the video link to assist them in performing the test.

Nutrition

PTH-7 REVIEW OF PATIENTS WITH COELIAC DISEASE IN NORTHERN ENGLAND

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Introduction The BSG and NICE recommend long-term regular follow-up of patients with Coeliac disease (CD). It is unclear when and what to be done when following a newly diagnosed CD patient and who should perform this review. The Northern Nutrition Network is multi-disciplinary, meets regularly and involves all acute Trusts in the north-east and north Cumbria. It is recommended that we check FBC, U&Es, LFTs, bone profile, Vit D and CD serology.

Aim To assess the follow up of patients with CD across the region.

Method A retrospective review of CD follow up using patient's records. All regional acute Trusts were invited to participate. A questionnaire was developed and circulated. Follow up data, for upto 2 years after the diagnosis of CD, were recorded for up to 20 patients per Trust, diagnosed after 1.1.2017.

Results 141 responses received from 8 of 9 trusts. Median age was 41 years. 38% (54/141) were male. Histology was consistent with CD in all patients. EMA was positive when tested in 92%, negative in 8% - not tested 17%. TTG was positive when tested in 95%, negative in 5% - not tested in 6%. TTG values varied from 6.4U/ml to >1000 U/ml.

Following diagnosis, 70% of CD patients were followed up by gastroenterologists in first 4 months, 88% in their first year and 89% in 2 years. Only 11% (16/141) did not see a gastroenterologist in the first 24 months after diagnosis. 90% of CD patients were seen by dietician in first 4 months, 91% in first year and 91% in 2 years following diagnosis. 9% were not seen by dietician. There were 2 trusts in which patients were followed up by nurse specialist as well.

Weight was measured at review in 92% in 1st year and 71% in 2nd year. BMI was recorded for 71%. Dietary compliance was recorded in 85% at review: 60% were fully compliant to gluten free diet (GFD), 15% had occasional lapses, only 10% were not compliant.

4% did not have FBC or LFTs and 2% U&Es checked in first 24 months. 12% did not have calcium and 41% did not have Vit D checked in first 24 months. Serology was checked in 83% in 1st year, 53% in the 2nd year, 12% did not have serology in first 24 months. Following review of blood tests results, actions taken on abnormal results: Folic acid supplemented 6 times, Vit D supplemented 17 times, Iron 15 times, Vit B12 4 times and Calcium 3 times.

Repeat duodenal biopsy was undertaken within 2 years in 15% of patients. Estimation of fracture risk was recorded in 16% but BMD measurement within 2 year was in 66%. In 18% advice was given on vaccination during the review.

Conclusion Practice in the follow-up of patients with CD varied. Blood tests are checked regularly but we are poor in recording vaccination advice and perform BMD rather than estimate fracture risk non-invasively. Repeat duodenal biopsy is unusual. There is a need of robust follow up regimens across the region.

PTH-8 NOMOGRAM RELIABILITY FOR PREDICTING SURVIVAL IN PATIENTS WITH INCURABLE CANCER REFERRED FOR HOME PARENTERAL NUTRITION

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Introduction In the presence of bowel obstruction, enterocutaneous fistula, short bowel, or severe mucosal disease, patients with incurable cancer are increasingly being referred for consideration of home parenteral nutrition (HPN). The decision to commence such treatment largely relies on expert opinion rather than robust data showing survival outcome. To address this shortcoming, a nomogram to predict median survival length in palliative cancer patients treated with HPN has been developed and validated.¹ The nomogram is based on Glasgow prognostic score (CRP & albumin), primary cancer, metastases and Karnofsky performance status. The aim of this study was to assess the reliability and clinical value of the nomogram.

Methods The nomogram was applied ambidirectionally to adult patients referred for palliative HPN between 1/3/15 and 7/7/20 at one tertiary HPN centre. Patients receiving chemotherapy or radiotherapy at the point of referral or during HPN treatment, and patients with neuroendocrine tumours were excluded. Intraclass correlation coefficient (ICC) was used to measure the reliability of the nomogram.

Results 35 patients were identified. Eight patients were excluded due to commencing chemotherapy. Of the 27 remaining patients, 15 (66%) were female. 16 (59%) patients had primary GI cancers, six (22%) ovarian, and five (19%) other forms of cancer. Overall mean survival was 114 days (22-433) versus 104 days (30-200) for predicted survival ($p=0.746$). The nomogram over predicted survival in 59% of cases and under predicted in 33%. The predictions for seven patients (26%) were within 20% of their actual survival, 12 patients (44%) were within 50%, and the remaining patients between 50 and 248%. The ICC was 0.327 with a confident interval of -0.64-0.627, indicative of poor reliability.²

Conclusion Although the p value suggests no significant difference between predicted and actual survival length, our study is limited by the small sample size. We considered a 20% variance between predicted and actual survival clinically acceptable; only a quarter of patients were within this range. Our study therefore does not support the use of the nomogram to predict survival in patients referred for palliative HPN and we should continue to use clinical acumen when considering such