Introduction Traditional management of malignancy related ascites (MRA) is via large volume paracentesis (LVP). NICE recommends indwelling peritoneal catheters, (IPCs) which are cost effective and patient centred. A service and practice guidelines were set up. Ongoing reviews assess safety and efficacy and inform future pathways.

Methods A single centre retrospective analysis of patients requiring IPCs between October 2018 and December 2020 was performed. Demographics and outcomes were collected. Descriptive statistical methodology was applied. IPCs are placed in theatre or dedicated clean spaces, with pre-operative antibiotics.

Results 29 patients (14 male, 15 female) underwent 30 IPC placements. [1 patient had 2 IPCs (this will not be discussed as case is published)]. Diagnoses were, breast (2), ovarian (5), prostate (1), thymic (1), unknown primary (5) cancers and 1 mesothelioma. The majority were for gastrointestinal cancers. 3 had no preceding LVP; 26 had a mean of 2.2 LVPs before. 6 developed post-operative leaks. 2 patients developed cellulitis. Bacterial colonisation occurred in 1 patient. 4 IPCs were removed: 2 as ascites resolved, 1 for tumour infiltration, 1 for non-resolving site cellulitis. 24 patients have died: mean number of days to death: 60.1 (range 6-262). Integrated Palliative Care Outcome Scale scores collected in patients consistently show sustained reduction in pain, dyspnoea, nausea, vomiting, drowsiness, distension and improvements in body image and appetite.

Conclusions

IPCs are safe and efficient More formal evidence is required on some aspects namely a systematic review of the literature, a study to determine if patients with MRA should have an IPC at first presentation and correlate with quality of life outcomes and a national collaboration on numbers of IPCs being inserted and related outcomes.

PTH-39 DELAYED DIAGNOSIS IN HEREDITARY HAEMOCHROMATOSIS – POTENTIAL UTILITY OF ‘CASE-FINDING’ APPROACH

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Introduction Hereditary haemochromatosis is a common genetic disorder, with a prevalence of 0.25-1% in the UK population. It has variable clinical penetrance, with men more frequently affected. Progression to liver cirrhosis can be prevented with early diagnosis and venesection. Increased testing of serum ferritin may lead to increased diagnosis, although haemochromatosis may still be overlooked, as elevated ferritin levels may be ascribed to malignancy or inflammatory disorders. If late diagnosis is common then a case-finding approach may identify patients earlier in their disease, with lower costs than a screening programme. The aim of this project was to identify whether patients with hereditary haemochromatosis are diagnosed within 6 months of an initial abnormal ferritin, and to estimate the number of patients that remain undiagnosed in Somerset.

Methods Somerset patients with haemochromatosis diagnosed between 2005-2020 were identified from clinic letters and venesection databases. Review of electronic blood results and clinic letters identified demographic data, time to diagnosis and ferritin result at diagnosis. For those with a delayed

diagnosis (defined as over 6 months after a ferritin >500), the number of pre-diagnosis ferritin results was recorded.

Results 124 patients (30 female, 94 male) were identified. 83 patients (20F, 63M) were diagnosed in Somerset after their first available ferritin estimation. 47 (56.6%) were diagnosed within six months of their first raised ferritin. Of those with a delayed diagnosis, 9 (25%) took over 3 years to be diagnosed and 4 (9%) remained undiagnosed after 5 years. The higher the initial ferritin result, the more likely a patient was diagnosed within 6 months ($p=0.005$). Using published data for the prevalence and clinical penetrance of genetic haemochromatosis, we predicted the expected number of patients with overt haemochromatosis in Somerset. From our modelling we would expect to see 72 women and 412 men with overt clinical haemochromatosis in our population. This indicates that in Somerset 58% of women and 77% of men with clinically relevant haemochromatosis may be undiagnosed.

Conclusions Our data show that diagnosis was delayed in almost half of Somerset patients with haemochromatosis. Additionally, it is a significantly underdiagnosed condition. Given that early initiation of venesection can reduce the risk of developing complications, improving the diagnostic pathway for patients with haemochromatosis using a ‘case-finding’ approach should be prioritised.

PTH-40 PREVALENCE OF UNDIAGNOSED PRIMARY BILIARY CHOLANGITIS AND THE POTENTIAL UTILITY OF A ‘CASE-FINDING’ APPROACH

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Introduction Primary Biliary Cholangitis (PBC) is a progressive, autoimmune disease for which treatment improves 10-year transplant free survival from 60% to 80%. The observed variance in prevalence of PBC (1.91-40.2/100,000) may be in part explained by underdiagnosis. Liver function tests (LFTs) are frequently measured, but abnormalities are under-investigated. The purpose of this audit was to determine the rate at which abnormal alkaline phosphatase (ALP) results were investigated and whether patients meeting diagnostic criteria for PBC were referred in line with current guidelines. If existing laboratory data can identify missed PBC, there is potential to use a case-finding approach.

Methods We interrogated our laboratory system (population of 500,000; 2011-2018) using the audit tool PathManager™ to identify potential patients aged 40-60. Individuals with >3 abnormal ALP results, and ≥ 1 result >150 IU/L were identified. Patient results were screened for malignancy; bone pathology; known AMA status; and acute resolving elevated ALP. Unexplained raised ALP were labelled ‘possible missed PBC’. Separately antimitochondrial antibody positive (AMA +ve) patients were identified. Patients with a known PBC diagnosis were excluded. Those with a raised ALP trend, +ve AMA and no diagnosis were labelled ‘missed PBC’.

Results 2814 patients had raised ALP on >3 occasions. 1551 of these (55.2%) had an AMA result (76 +ve). 1263 (44.8%) had no previous AMA result; of these, 437 (34.6%) had cancer, 76 (6.0%) underlying bone pathology and 181 (14.3%) had an acute abnormality which resolved. 575 (20.4% of the total) had no cause identified. In a sample of patients with a

Abstract PTH-40 Figure 1

raised ALP with no other explanation who had AMA tested, 15.2% were AMA +ve. Applying this to our group with no AMA or alternative explanation for raised ALP, 87 cases of PBC may have been missed with only 46.6% of patients with PBC appropriately investigated and diagnosed. Separately 349 AMA +ve patients were identified. 35.0% had a normal ALP, 14.3% had a intermittently/borderline raised ALP, and 44% had a persistently raised ALP; of these 21.9% were not known to secondary care. [Figure 1]

Conclusions From data on individuals with previous LFTs we estimate that >50% of patients with PBC in Somerset remain undiagnosed, and over 20% meeting diagnostic criteria of PBC were not referred. These data show that for patients who have had LFTs performed, analysis of laboratory data and a 'case-finding' approach could be effective in reducing liver disease related harm.

PTH-41 OUTCOMES OF THE MODIFIED PATHWAY FOR URGENT UPPER GI CANCER REFERRALS DURING THE COVID-19 PANDEMIC

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Introduction There has been significant change in endoscopy referral pathways as departments reorganise their services during COVID-19. As per BSG guidance, a modified referral pathway was instituted locally for patients with urgent suspicion of upper gastrointestinal cancer (USOC-UGI). We aimed to assess the impact of this modified pathway on outcomes of USOC-UGI referrals during the deceleration and early recovery phases of endoscopy provision during COVID-19 at our institution.

Methods We performed a retrospective observational single-centre study, comparing outcomes of the COVID-impacted USOC-UGI pathway from March to June 2020 to the corresponding pre-COVID period in 2019 when all patients had straight to test endoscopy. During the COVID-impacted period all patients referred were first assessed in a virtual clinic (VC) by a consultant gastroenterologist. Risk stratification and the Edinburgh dysphagia score (EDS) questionnaire were used to triage patients; alternative investigations such as barium study and CT requested when indicated. The primary outcome was cancer detection rate. We also assessed vetting outcomes, symptom concordance, and delayed cancer diagnosis at 6-month follow-up.

Results 253 patients were included in the study. 118 patients were referred through the modified COVID-impacted pathway and 135 in 2019, indicating a drop in referrals by 12.5% ($p=0.13$). The median age was similar (66.5yrs in COVID impacted *vs* 67yrs pre-COVID). The most common reason for referral during both periods was dysphagia (58.5% *vs* 62.9%; $P=0.221$). Symptom concordance between those recorded in the referral and those reported at the time of VC was 86.4%. Following VC, 27/118 (22.9%) patients were deemed not to require UGI investigations of which 9 (7.6%) stated that their symptoms had resolved. Nearly half (55.3%) of the patients reviewed in VC were referred for an alternative investigation to endoscopy, of which barium swallow and meal was most common 36/57 (63%). Overall, the rate of upper GI cancer diagnosed between both periods was not statistically different (8.5% *vs* 5.2%; $P=0.3$). All patients diagnosed with oesophageal cancer reported to have symptoms of dysphagia and had a calculated EDS of ≥ 5 . There has been no delayed cancer diagnosis at 6-month follow-up.

Conclusions The rate of UGI cancer was similar between the two time periods. Initial virtual consultation reduced the demand for endoscopy or alternative investigations by nearly a quarter. Dysphagia remains an especially worrisome symptom and the incorporation of EDS questionnaire in this pathway appears appropriate. The use of alternative investigations in a select group of patients during restricted endoscopy services seems safe although long-term follow-up data is still required.

PTH-42 UTILISING A FRAILTY SCORING TOOL IMPROVES THE APPROPRIATENESS OF EMERGENCY GI BLEED ENDOSCOPY

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Introduction Risk assessment tools have been used for over 20 years to determine the need and timeliness of endoscopic intervention in patients with symptoms of acute upper gastrointestinal bleed (AUGIB), but with easier access to procedures and an increasingly frail population being referred for emergency and aggressive management the addition of a clinical frailty score (CFS) to existing pathways should be considered. This study looks at the patient factors leading to the emergency gastroscopy (OGD), co-morbidity and survival.

Methods Clinical, endoscopic and outcome data were collected for all adult patients referred for emergency AUGIB gastroscopy during a 12 month period. Frailty was scored by the endoscopist using the 9 point Rockwood CFS (Rockwood, et al., 2005). Follow up data were collected until death or for a minimum 1 year and analysed using GraphPad Prism version 8.0.0, USA.

Results 143 patients underwent OGD in line with NICE CG141 guidance. Survivors were followed up for an average 85 weeks (range 53-126). Of the 143 patients, 90 (63%) were males, the median age 73 years and 41 (29%) patients >80 years old. In total 17 (12%) died during admission, 15 (11%) <4 weeks, 23 (16%) <12 weeks and 44 (31%) <52 weeks. 56 (39%) patients in total died during follow up.

11 patients had Blatchford score ≤ 2 , average age 38 years. One patient passed away at week 39 of unrelated illness and no AUGIB at OGD. All scores ≤ 2 had coexisting non-GI issues contributing to their presentation.