urgent inpatient colonoscopy. Average time till patients received urgent inpatient endoscopy was 2.88 days. Of 15 patients who required transfusion, 12 were correctly transfused. 57.80% of patients had warfarin or DOAC stopped at presentation. 5.26% of patients had anticoagulation correctly restarted following haemostasis. Similarly 40.00% of patients had aspirin stopped at presentation and 0.00% and 15.38% of patients had aspirin restarted correctly for primary and secondary prevention respectively.

Conclusions Auditing against a new standard has revealed worrying data and highlights the importance of change to practice that these guideline provide. This is best seen with the improper management of patients on anticoagulant and antiplatelet agents. However, the guideline is arguably overly cautious and strict adherence would place significant strain on a DGH. We propose several amendments to the guideline such as redefining admission criteria and the approach to managing unstable LGIB. Our modified guideline shows minimum expected clinical practice that is conducive to high quality patient care within the limits of hospital resources.

P388 COGNITIVE IMPAIRMENT PREDICTS MORTALITY AND LONGER ADMISSIONS FOR INDEX PRESENTATIONS OF ALCOHOL-RELATED LIVER DISEASE

[1,2]Anahita Sharma*, [1]Constantinos Kallis, [1]Pete Dixon, [1,2]Benjamin Silberberg, [2]Steve Hood, [1,2]Keith Bodger. [1]*University of Liverpool, Liverpool, UK*; [2]*Aintree University Hospital, Liverpool University Hospitals NHS Foundation Trust, Fazakerley, Liverpool, UK*

10.1136/gutjnl-2020-bsgcampus.462

Introduction Alcohol-related liver disease (ARLD) can present with neuropsychiatric complications. Epidemiological studies have not investigated the impact of confusional states on patient journeys. As part of the Connected Health Cities programme, we retrospectively investigated coding data from a regional administrative dataset to identify the burden of recognised cognitive impairment (CI) in a pre-identified cohort of patients during their index admission of ARLD (fiscal years 2014–18).

Methodology Inpatient spells for a cohort of 3,887 index ARLD admissions were screened for ICD-10 codes indicative of acute and chronic CI. Descriptive analytics and stepwise multivariate logistic regression models were generated using Stata 15 (StataCorp, 2017) for predefined outcomes: inpatient mortality, length of stay, all-cause outpatient attendance and all-cause A&E attendance. These were casemix-adjusted for age, sex, co-morbidity, deprivation and variables associated with severity of liver decompensation.

Results 20 codes corresponded to acute or chronic CI, most frequently encoding encephalopathy and alcohol-related amnesiac syndrome respectively. Codes for intoxication and withdrawal were excluded and adjusted for. 277 spells (7.1%) were coded with $\geq$ 1 ICD code for acute CI, and 78 (2.0%) for chronic CI, with minimal overlap (0.6%). Comparisons were made with patients without relevant codes. Overall, these patients were older (mean age 57.5 and 64.1 respectively) with higher levels of co-morbidity (mean Charlson index 16.4 and 12.6 respectively) with median bed-days of 13 and 14. Multivariate logistic regression models demonstrated patients with acute CI had higher odds of inpatient mortality (OR 2.13) and long admission $\geq$21 days (OR 2.30). Patients coded with chronic CI had higher odds of long admission (OR 3.09) and A&E attendance within 90 days (OR 2.01), and were less likely to attend an outpatient clinic at 14-day (OR 0.28) and 30-day (OR 0.4) intervals post-discharge. CI did not predict risk of readmission.

Conclusion In terms of mortality, acute CI is likely to reflect higher disease severity, particularly as encephalopathy is a poor prognosticator in this group of patients. The evidence suggests that chronic CI in patients with ARLD is underdetected in clinical practice. Our analysis demonstrates patients with recognised chronic CI experience extended admissions, are more likely to experience unplanned care and less likely to engage with outpatient care up to 90 days post-discharge. This suggests that current care models may not be appropriate for this subgroup, and alternative pathways integrating prompt identification and supported discharge mechanisms should be developed.

P389 VAGUE ABDOMINAL SYMPTOMS PATHWAY: IS IT WORTH IT?

[1]Panagiotis Stamoulos*, [1]Ketul Patel, [1]Robyn Jenkins, [1]Nicola Beech, [1]Claire Walters, [1,2]Jennifer Ross, [1]Sanjay Gupta. [1]*Croydon University Hospital, London, UK*; [2]*St George's Hospital, London, UK*

10.1136/gutjnl-2020-bsgcampus.463

Introduction The time to diagnosis for patients with suspected cancer in the NHS is often excessive leading to unnecessary distress for patients and contributing to the poor survival rates in the UK compared to Europe. The Accelerate, Coordinate, Evaluate (ACE) Programme is an early diagnosis of cancer initiative focused on testing innovations that either identify individuals at high risk of cancer earlier or streamline diagnostic pathways.

Croydon University Hospital was chosen as one of three hospital sites across West London to participate in this pilot project. The aim was to implement and evaluate a vague abdominal symptoms (VAS) referral pathway from general practice to acute oncology within Croydon in order to reduce emergency admissions and late presentation of cancer.

Methods The pathway was implemented from April 2017 to March 2018. The pathway required GP practices to refer according to defined eligibility criteria. All referrals were triaged by an Acute Oncology Nurse specialist and reviewed in a dedicated gastroenterology clinic. All patients underwent initial investigations within 14 days of clinic review. Virtual clinic and feedback was provided to GPs and patients after completion of investigations.

Results 60 patients were referred of which 51 were assessed on the pathway (7 did not meet eligibility criteria and 2 refused to be seen) with a median age of 56 years. Commonest referral indication was abdominal pain (73%).33% of patients had visited their GP at least three times for symptoms meeting the eligibility criteria of the pathway.

34 (67%) patients had endoscopy and 41 (80%) had radiology investigations. 23 (45%) of patients had more than 3 tests. Metastatic cancer was detected in 2 patients-splenic sarcoma and squamous lung carcinoma. 15 (29%) of patients had significant benign conditions including mesenteric ischaemia, Crohn's disease, granulomatous gastritis, intraductal papillary mucinous neoplasm, lymphocytic enteritis, gallstones, gallbladder polyps, colonic polyps and hydrosalpinx. 34 (67%) patients had other benign conditions. Median time to final diagnosis was 57 days (the 2 cancers were diagnosed at 7 and 34 days).

Gut: first published as 10.1136/gutjnl-2020-bsgcampus.463 on 21 January 2021. Downloaded from http://gut.bmj.com/ on February 2, 2021 by guest. Protected by copyright.

Conclusions Implementation of the VAS pathway in Croydon demonstrated a 4% cancer conversion rate and a 29% conversion rate for clinically significant benign pathology although it did not reduce time to diagnosis.

Integration of a VAS pathway in existing clinical services should be considered for diagnosis of benign but relevant symptomatic conditions.

A VAS pathway could potentially assist GPs in referring patients early which should translate into early diagnosis of cancers not necessarily confined only to the gastrointestinal tract although more data is required to support this.

P390 MENTAL HEALTH DISORDERS AND LENGTH OF STAY IN GASTROENTEROLOGY INPATIENTS AT A UNIVERSITY TEACHING HOSPITAL

[1]Cansu Beril Sahin, [2]Nicola Taylor*, [1]Louise Downey, [1]Tilly Mills, [1]Ana Miorelli, [1]Markus Gwiggner. [1]*University Hospital Southampton NHS Foundation Trust, Southampton, UK*; [2]*Royal Bournemouth And Christchurch Hospitals, UK*

10.1136/gutjnl-2020-bsgcampus.464

Introduction University Hospital Southampton (UHS) NHS Foundation Trust provides services to over 1.3 million people. Mental health disorders (MHDs) affect over 40% of hospital inpatients,[1] but the prevalence in gastroenterology inpatients is not known. A 2017 NICE consultation on Liaison Psychiatry Services[2] highlighted reduced length of stay as an important outcome for medical patients with a MHD. We explored the prevalence of psychiatric comorbidities in our gastroenterology inpatients, contact with psychiatric services, and the associated length of stay (LoS), providing a rationale for dedicated specialized gastroenterology inpatient psychiatric liaison support.

Methods Electronic health records for 200 consecutive gastroenterology admissions between January and December 2018 were retrospectively interrogated. Demographic data, diagnosis, co-morbidities, psychiatric input and LoS were recorded.

Results 82/200 (41%) gastroenterology inpatients had a pre-existing MHD. Depression was most prevalent condition (59%), followed by alcohol dependency (20%) and anxiety (19%). Patients admitted with exacerbations of chronic conditions (e.g. inflammatory bowel disease (IBD), gut dysmotility) had a higher prevalence of MHD (46%) versus patients with acute gastrointestinal illness (e.g. gastroenteritis, GI bleeding) without a pre-existing MHD diagnosis (35%). Patients with nutritional failure had the highest mental health burden of all GI diagnoses with a MHD prevalence of 44%, closely followed by IBD at 42%. Mean LoS with or without psychiatric co-morbidity were 12.9 and 8.9 days respectively. 17/200 (8.5%) patients were assessed by the hospital psychiatric liaison service (7 consultant reviews, 3 junior doctor, 4 mental health nurse and 2 psychologist). Mean LoS in this group was 17 days. 4 patients had no pre-existing diagnosis of MHD and following review 3 of these patients (75%) received a new MHD diagnosis.

Conclusion Psychiatric co-morbidities were very prevalent in our gastroenterology inpatient cohort and were associated with an increased LoS versus patients without MHD. Those who received general psychiatry liaison input had a longer LoS which may reflect disease complexity or delay to psychiatry review due to limited resources. Early identification of patients with known MHD and provision of a dedicated gastrointestinal psychology service is important to provide holistic care to a complex group of patients and aim to reduce inpatient stay. A new dedicated psychiatric liaison service has consequently been implemented at UHS with plans to reassess impact upon LoS and patient outcomes.

REFERENCES

1. https://www.nice.org.uk/guidance/ng94/documents/draft-guideline-23
2. Rothenhäusler HB. Mental disorders in general hospital patients. *PsychiatrDanub*. 2006 Dec;**18**(3–4):183–92.

P391 AN EVALUATION OF A NURSE ENDOSCOPIST LED VIRTUAL CLINIC FOR MANAGEMENT OF COLONIC POLYP SURVEILLANCE

Margaret Vance*, Angeline Chai, Belma Motes, Anna Buenaventura, Adam Humphries. *St Mark's Hospital, London, UK*

10.1136/gutjnl-2020-bsgcampus.465

An evaluation of the nurse endoscopist led virtual polyp surveillance clinic for the implementation of the British Society of Gastroenterology (BSG) 2019 Post polypectomy and post colorectal cancer resection surveillance guidelines, assessing the impact on patient safety and satisfaction, colonoscopy capacity and colonoscopy surveillance waiting times.

Methods A protocol was designed to manage colonoscopy polyp surveillance in a virtual nurse led clinic with two aims:

- Retrospectively review all patients currently undergoing colonoscopy surveillance for sporadic polyps and post colonoscopy cancer surveillance to determine the correct surveillance intervals or discharge.
- Prospectively review all new post colonoscopy polypectomy referrals to determine the correct surveillance intervals or discharge.

Exclusion criteria

- Family history of cancer patients – under the care of Family Cancer Clinic.
- Lynch syndrome patients – under care of Family Cancer Clinic
- FAP and any polyposis syndromes – under care of Polyposis Registry

The virtual clinic started in October 2019; all colonoscopy and histology results were reviewed and recorded from the index procedure. The administration team identified all patients requiring polyp and post colon cancer resection surveillance for the following 4 months (700 patients in total) .A prospective virtual clinic was also set up to review polyp histology from colonoscopies performed in the preceding 30 days. A patient and GP letter was designed; all reviews and outcomes were recorded on the hospital reporting systems and a helpline and email address were identified for patient and GP queries.

Results 2934 patients were identified on a polyp surveillance programme with a recall of 1, 3 or 5 yearly colonoscopy. Between October and December 2019, 629 retrospective reviews were performed for patients who were due for colonoscopy within the next 4 months. After review, 335 were discharged from surveillance (53%) 274 remained on surveillance (44%) and 20 patients had surveillance dates altered, from 1 -3 years (3%). There were 5 patient queries and 2 GP

Gut: first published as 10.1136/gutjnl-2020-bsgcampus.463 on 21 January 2021. Downloaded from http://gut.bmj.com/ on February 2, 2021 by guest. Protected by copyright.