Abstarct PWE-59 Table 1 Physiology parameters and VAS scores

Modality (parameters recorded, unit) *n=20*	Median resting result (IQR)	Abnormal/ Normal	Median squeeze result (IQR)	Abnormal/ Normal	Median VAS score (*IQR*)
HRAM (Resting/Incremental Squeeze pressure, cmH_2O)	40.04 (25.6 – 76.5)	Abnormal	81.4 (54.4 – 147.0)	Normal	1 (*0 – 2.8*)
FLIP (Distensibility index, $mm^2/mmHg$)	1.6 (0.8-1.7)	Abnormal	0.7 (0.5-1.6)	Abnormal	0 (*0 – 1*)
AAR (Opening/Squeeze opening pressure, cmH_2O)	41.4 (25.1 – 63.1)	Abnormal	79.8 (46.1 – 124.9)	Abnormal	0.5 (*0 – 1*)

assessment of anorectal function is crucial in those with FI however, fear of tests/investigations can be a barrier to accessing services. Further qualitative research on patients perceptions/preferences of anorectal investigations and treatments will help to provide education for health practitioners and service users, and hopefully improve the patient journey experience.

PWE-60 UNDIAGNOSED PSYCHOPATHOLOGY IS PREVALENT AND SIGNIFICANT IN PATIENTS ATTENDING A TERTIARY NEUROGASTROENTEROLOGY CLINIC

[1]Alicia Green, [1]Inga Daugirdaite*, [1,2]Qasim Aziz, [1,2]Asma Fikree. *[1]Wingate Institute of Neurogastroenterology, London, UK; [2]Barts Health NHS Trust, London, UK*

10.1136/gutjnl-2021-BSG.322

Introduction According to the biopsychosocial model for functional gastrointestinal (GI) disorders, the presence of psychopathology influences symptom presentation and should be targeted in the management plan. We aimed to determine what proportion of patients attending a tertiary neurogastroenterology clinic had evidence of anxiety, depression and eating disorders which had not been previously identified, but which may be very important for treatment strategies.

Methods Consecutive patients attending a tertiary neurogastroenterology clinic completed validated questionnaires to screen for anxiety and depression (HADS-A/D>11), eating disorders (SCOFF>=2), avoidant restrictive eating disorders (ARFID using NIAS > 28), personality disorders (SAPAS > 2), GI symptoms (GSRS), visceral sensitivity index (VSI) and quality of life (QOL using SF36). They were asked specifically about a history of anxiety, depression and eating disorders. Questionnaire scores were compared using a Mann Whitney U test – in view of the multiple comparisons a p value< 0.01 was considered significant.

Results 186 patients (aged 16-84, 85% female) completed the questionnaires. 41 patients (22%) screened positive for depression and 73 (39%) for anxiety, though a third of each of these did not document a diagnosis of depression or anxiety. 22% screened positive for an eating disorder and 25% for ARFID, although only 16% documented a diagnosis of an eating disorder. 48% screened positive for a personality disorder. Patients who screened positive for depression and anxiety had more severe GI symptoms, particularly pain, higher VSI and worse QOL (Table 1).

Abstract PWE-60 Table 1

	Negative depression screen	Positive depression screen	P value	Negative anxiety screen	Positive anxiety screen	P value
Mean overall GSRS	3.54 ± 1.10	4.21 ± 1.11	0.001	3.47 ± 1.06	4.03 ± 1.18	0.001
Mean GSRS abdo pain	3.78 ± 1.27	4.75 ± 1.19	<0.0001	3.78 ± 1.33	4.34 ± 1.22	0.005
Mean GSRS reflux	3.19 ± 1.90	3.87 ± 2.00	0.06	3.16 ± 1.95	3.63 ± 1.89	0.086
Mean GSRS indigestion	3.82 ± 1.51	4.19 ± 1.53	0.204	3.67 ± 1.52	4.26 ± 1.46	0.01
Mean GSRS diarrhoea	3.01 ± 1.86	4.08 ± 1.79	0.001	2.96 ± 1.84	3.69 ± 1.90	0.01
Mean GSRS constipation	3.70 ± 1.97	4.15 ± 1.94	0.213	3.66 ± 1.93	4.02 ± 2.01	0.238
SF36 General health	30.85 ± 19.60	14.05 ± 10.78	<0.0001	31.31 ± 19.77	20.35 ± 16.56	<0.0001
SF36 Physical functioning	51.50 ± 34.04	27.50 ± 27.26	<0.0001	51.14 ± 34.52	38.06 ± 32.03	0.007
SF36 Social functioning	47.25 ± 30.66	16.07 ± 21.61	<0.0001	48.54 ± 31.16	27.08 ± 27.91	<0.0001
SF36 Energy/ fatigue	31.06 ± 20.84	12.02 ± 26.69	0.001	32.61 ± 21.98	17.57 ± 15.83	<0.0001
VSI score	36.11 ± 18.29	45.41 ± 20.60	0.006	34.81 ± 18.99	43.36 ± 18.56	0.006

Discussion/conclusion Simple questionnaire screening identifies a high prevalence of psychopathology in patients attending neurogastroenterology clinics, a third of whom had no documented diagnosis of psychopathology, so this would have been missed by simple history taking. Patients who screen positive for psychopathology have more GI symptoms and worse QOL so it is important to identify this as addressing it may improve GI symptoms. Having a dedicated gastro-psychologist in neurogastroenterology centres would help with screening and managing these difficult conditions yet the majority of UK centres do not have access to this.

PWE-61 AN EARLY EVALUATION OF PARTICIPANT RECRUITMENT AND COMPLIANCE FOLLOWING THE VIRTUALISATION OF RELIEVE IBS-D TRIAL

[1]Cho Ee Ng*, [2]C Howell, [2]A Kemppinen, [3]H Forsyth, [3]G Richell, [2]E Markaryan, [4]J McLaughlin, [5]C Knowles, [1,3]Yan Yiannakou. *[1]University Hospital North Durham, Durham, UK; [2]EnteroMed Ltd, London, UK; [3]NIHR patient recruitment centre, Newcastle, UK; [4]University of Manchester, Manchester, UK; [5]Queen Mary University of London, London, UK*

10.1136/gutjnl-2021-BSG.323

Introduction Irritable bowel syndrome (IBS) is a common condition but recruitment to IBS clinical trials has been challenging due to non-specialist follow-up, poor diagnostic coding, and complexity of ROME IV criteria. The RELIEVE-IBSD study was delivered partly as a traditional site-dependent trial (SDT) and a remote virtual trial (VT). We aimed to compare