

PTU-092 THE MANAGEMENT OF ALCOHOL WITHDRAWAL IN PATIENTS WITH ADVANCED LIVER DISEASE

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Introduction Alcohol withdrawal syndrome (AWS) is a common reason for hospital admission. However a significant number of these patients have co-existent liver disease or other medical problems. There is little information regarding the management of these patients.

Methods Patients were assessed for hazardous drinking using the FAST score. Data was collected prospectively on FAST positive patients with regards to their subsequent treatment using a unified AWS guideline. Patients with known liver disease or presenting with decompensated liver disease were identified (Group 1) and compared with patients admitted with non-hepatic primary alcohol-related diagnoses (Group 2) and patients with admitted primarily non-alcohol related medical diagnoses (Group 3). Results are expressed as median (95% confidence).

Results 53 patients had significant liver disease (Group 1), with 153 in Group 2 and 106 in Group 3. Median MELD score in Group 1 was 15.4 [12.8, 17.6]. The three groups had similar FAST scores: 14 [12, 15], 14 [13, 14] and 13 [12, 14] respectively. Fewer patients in Group 1 and Group 3 required benzodiazepine (BZD) treatment compared with Group 2. When required, the median BZD prescription (mg diazepam equivalent) during admission was greater for Group 2 patients compared with Group 1 and Group 3 (Table). More patients in Group 1 were treated with lorazepam rather than diazepam; 13% *cf* 5% in Group 2 ($p = 0.1, -1, 20.4$) and 3% in Group 3 ($p = 0.04; 0.7, 22.3$). The proportion of patients requiring parenteral treatment for breakthrough symptoms were similar: Group 1: 5.6%, Group 2: 4.6%, Group 3 4.7%.

Abstract PTU-092 Table

	Not Requiring BZD	Median BZD use (mg diazepam equiv)
Group 1	14 (26%)*	70 (48, 111)\$
Group 2	16 (10%)*#	130 (105, 160\$~)
Group 3	35 (33%)#	40 (30, 80)~

* $p = 0.008$ (3.5, 30.5); # $p < 0.0001$ (12.4, 33.7); \$ $p = 0.003$; ~ $p = 0.0001$

There were correlations between the FAST score and subsequent amount of diazepam prescribed for Group 2 ($p = 0.002$; 0.09, 0.4) and Group 3 ($p = 0.03$; 0.02, 0.41), but not for Group 1 ($p = 0.26$; -0.12, 0.43). Overall survival until 33 months was less in Group 1 (64%) compared with Group 2 (84%; $p = 0.0007$ HR 0.29 [0.14, 0.60]) and Group 3 (81%; $p = 0.016$ HR 2.30 [1.17, 4.55]).

Conclusion Compared to patients admitted with primarily AWS or alcohol related seizures, patients with chronic liver disease and those with other medical problems were less likely to require any benzodiazepine therapy and require lesser amounts of such treatment. The expected association between indicators of harmful/dependent drinking and BZD requirement was lost in liver disease patients. Care should be taken to avoid unnecessary over-treatment of these patients.

Disclosure of Interest None Declared

PTU-093 HCC DIAGNOSED ON SURVEILLANCE PROGRAMMES: IMPACT ON STAGE AND OUTCOME

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Introduction Surveillance of cirrhotic patients for HCC is recommended by numerous national and international guidelines. However many patients are still diagnosed de novo with this malignancy. Data on the benefits of surveillance remains relatively limited. Our aim was to compare stage at diagnosis and patient outcome for those diagnosed on surveillance and those who were not.

Methods Using our regional HCC MDT database, we analysed patients diagnosed with HCC between January 2009 and January 2012. All patients were staged using the Barcelona Clinic Liver Cancer (BCLC) system. We compared the stage at diagnosis, the treatment strategy after MDT discussion, and the survival in those diagnosed on surveillance with those diagnosed de novo. Statistical comparisons were made using CHI-squared or Kaplan Meier analysis as appropriate.

Results 190 patients were diagnosed with HCC at MDT during the study period. We had full follow-up data on 169 patients which were used for analyses, with mean follow up 10 months. Mean age was 68 years and 82% patients were male. Aetiology was alcoholic liver disease in 32% and HCV in 15%. 38 (22%) patients were in surveillance programmes at diagnosis of HCC and 132 (78%) were not. Tumours were BCLC stage A at diagnosis in 28.9% patients in surveillance, compared with 6.1% not in surveillance ($p = 0.0003$). 15.8% those diagnosed in surveillance underwent transplantation or resection, compared with 2.3% who were not ($p = 0.004$). Survival for those diagnosed in surveillance was greater than those diagnosed de novo ($p = 0.01$)

Conclusion Most patients diagnosed with HCC in our region were not in surveillance programmes. Patients diagnosed on surveillance were more likely to have potentially curative disease and had higher overall survival.

Disclosure of Interest None Declared

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PTU-094 SHOULD LIVER BIOPSIES BE REPORTED BY PATHOLOGISTS WITH A SUBSPECIALIST INTEREST IN HEPATOLOGY?

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Introduction Histopathologists working in a district general hospital usually do not have a subspecialist interest in hepatology. Most district general hospitals have a gastroenterology service and local pathologists usually report liver biopsies. The Royal College of Pathologist (RCP) recommend that 'as minimal acceptable practise' a liver biopsy report should include the clinical diagnosis, biopsy size, overall architecture, degree of fibrosis, severity in chronic liver disease (staging/grading), a definitive diagnosis or discussion of the differential diagnosis. Appropriate negative findings (e.g. lack of iron overload or alpha-1-antitrypsin globules) should be documented in the report.

Methods A retrospective analysis of all liver biopsies between January 2010 to February 2012 at two district general hospitals (Barnet and Chasefarm NHS trust) in North London was performed. Data was collected from medical records and electronic results. Our aim was to assess whether liver biopsies provided the clinician with adequate information about diagnosis.

Results 107 liver biopsies were performed during this period under ultrasound guidance by a radiologist. Mean patient age was 62 years (Range 19–90). The mean number of core biopsies per patient was 1.5 (range 1–6). 10.7% (10/107) of the report did not mention a clinical diagnosis. 30% (32/107) of the biopsy report did not have a

definitive or a differential diagnosis about possible aetiology of underlying liver disease. However 98% (47/48) of patients with cancer had a diagnosis on histology. Only 53% (9/17) patients with chronic hepatitis had severity scoring (Ishak staging/grading).

Conclusion About one third of liver biopsies did not have diagnosis or discussion about a differential diagnosis. This number goes up to 47.5% (28/59) if we exclude malignancies. 9/28 specimens were sent to a tertiary centre and reported by a liver pathologist who gave a definite or differential diagnosis in all cases. The mortality associated with percutaneous liver biopsy ranges between 0.13 and 0.33% from an audit from UK district general hospital. With the advent of fibroscan there is less need to perform liver biopsies except in diagnosing malignancies or in hepatitis of unknown/unclear aetiology. From our study we conclude that non-cancer liver biopsies should be reported by pathologists with subspecialist interest in hepatology or the procedure should be performed in a tertiary hospital to give the clinician an accurate diagnosis to aid treatment.

Disclosure of Interest None Declared.

PTU-095 LIVER LESIONS ON ULTRASONOGRAPHY: IS IT CANCER OR NOT?

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Introduction The ultimate goal of the United Kingdom Cancer plan is to 'offer patients a maximum one month wait from an urgent referral for suspected cancer to the beginning of treatment'. The North London Cancer Network has devised and implemented a suspected cancer referral form for General Practitioners in London for patients to be seen within two weeks of referral to secondary care. One group referred on the suspected cancer referral form is patients with a liver lesion on ultrasound (USS). However, for a service to be effective it is essential that it is not overloaded with inappropriately referred patients.

Methods The aim of the study was to assess the appropriateness and findings in patients referred to secondary care with a liver lesion on USS. A retrospective analysis of all patients referred to the gastroenterology clinic with a liver lesion on USS on the suspected cancer referral form during a 12 month period from 1st January 2011 at a District General Hospital in North London (Chasefarm Hospital) was performed. Data was collected using medical records and electronic patient results.

Results In the study period, a total of 379 patients were referred with suspected upper GI cancer. Of these 39 (10.3%) were specifically referred in view of an abnormal liver lesion. The USS findings which prompted a referral was liver metastasis in 10 (26%), hypoechoic lesion in 7 (18%), liver mass in 6 (15%), hemangioma in 4 (10%), area of increased echogenicity in 3 (8%), isoechoic lesion in 3 (8%), cyst in 2 (5%) and hyperechoic lesion, echo poor area, echo bright area, calcified foci in 1 patient each (3%). All patients were seen in the clinic within 2 weeks and 29 (74%) had a CT and 7 (18%) had an MRI scan.

After review of images and/or histology in the clinic/multidisciplinary meeting, 10 patients had normal scan, 9 patients had hemangioma, 8 had liver metastasis, 5 had liver cysts, 2 patients did not attend follow up, 1 patient was too frail for further imaging, 1 patient each had hepatoma, adenoma, focal nodular hyperplasia and focal fat sparing.

7/10 (70%) patients with suspected metastasis on USS had confirmed metastatic disease on subsequent imaging. The 2 patients with liver cysts on USS had cysts on CT scan.

Conclusion The majority (77%) of patients with suspected cancer referred to the service did not have cancer. However, 70% of patients

with suspected liver metastasis on USS had this confirmed on CT scan. Simple cysts on USS proved to be cysts on CT. We recommend that if initial USS suggests metastases it is likely to be so and would recommend CT staging and tumour markers prior to outpatient review to expedite management. USS is highly sensitive in differentiating a cyst from a solid lesion and patients with cysts on USS can be offered a routine appointment rather than being seen as a potential cancer referral.

Disclosure of Interest None Declared

PTU-096 METABOLIC BONE DISEASE IN MILD CHRONIC LIVER DISEASE- IS IT WORTH CHECKING?

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Introduction Liver cirrhosis (LC) is increasing in frequency and can cause significant morbidity including metabolic bone disease (MBD) namely osteopaenia and osteoporosis, risk factors of fractures. It is vital that patients with MBD are identified and commenced on appropriate treatment. Whilst studies have investigated the prevalence of MBD in cirrhotics awaiting transplantation, the exact frequency of MBD in mild LC is not known. We aimed to assess the frequency of MBD in patients with mild LC (MELD score < 16) who had undergone DEXA scanning at our institution to ascertain whether routine screening is worthwhile.

Methods This was a single-centre retrospective study. From a radiology database, we identified 62 patients with histologically, radiologically and/or clinically diagnosed LC who had undergone a DEXA scan between May 2007 & June 2012. Osteopaenia and osteoporosis were defined using WHO criteria. Contemporaneous bloods were used to calculate the MELD. A similar number of age and sex-matched patients with histologically-confirmed coeliac disease (CD) who had had a DEXA scan were identified to act as a comparison group. The same scanner was used for all patients.

Results Patient characteristics

We identified 61 patients with LC and 45 with CD. The most common aetiologies were ALD (52%) and PBC (23%). The mean age for cirrhotics was 60.1 years (range 33–78) with 64% M and 36% F. The mean MELD was 10.7 ± 4.1 . For those with CD the mean age was 52 years (range 17–82) with 27% M & 73% F.

Patients with osteoporosis & osteopenia

Of the cirrhotics, 57% had MBD (36% osteopenia, 21% osteoporosis) compared to 62% of patients with CD (42% and 20% respectively). 57% of patients with ALD had MBD compared to 71% of patients with PBC. The mean age of those with LC and osteoporosis was 62.4 years (range 47–78) with 54% of patients being male. For those with CD and osteoporosis the mean age was 69 years (range 46–82) with 89% being female.

MBD in male ALD patients

Male ALD patients were at particular risk. There was a statistically significantly higher risk of MBD in male ALD patients (77.8%; 55.8–99.8%) compared to male CD patients (32.1%; 13.1–51.2%; $P < 0.05$.) On the other hand, female CD patients had a statistically greater risk of MBD vs females with ALD.

MELD score correlation with T-score

We found no correlation between the MELD score and the lumbar or hip T-score ($p = 0.803$.) Therefore, DEXA screening should be offered to all LC patients regardless of disease severity.

Conclusion All patients with LC, irrespective of MELD, should undergo DEXA scanning due to the high prevalence of MBD. Male ALD patients warrant particular attention due to the particularly increased risk of MBD and fractures.

Disclosure of Interest None Declared