hospital admission over 12 months and 8% required a TIPS procedure within 12 months. The actual cost of rebleeding episodes for the selected subgroup was 138 446, (3955 per patient). The theoretical cost of early TIPS in this group was calculated as 117 670, (3362 per patient). Assuming a rebleeding rate of 3% with early TIPS[1], this strategy has a potential cost reduction of 7% per patient outcome year compared with current standard management.
Conclusion The proportion of variceal bleed patients benefitting from early TIPS could approach 70% in regional centres. This has implications for the provision and organisation of interventional radiology services. Our retrospective analysis suggests marginal cost benefit, complementing the previously observed reduction in rebleeding and mortality; however prospective studies are needed to confirm this.

REFERENCE

1. **Garcia-Pagan JC,** Caca K, Bureau C, *et al*. Early use of TIPS in patients with cirrhosis and variceal bleeding. *N Engl J Med* 2010;**362**:2370–9.

P40 FAST TRACK JAUNDICE CLINIC: THE STANDARD OF CARE FOR HEPATOBILIARY MALIGNANCY?

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Introduction The Scottish Government has stated that 95% of people referred urgently with a suspicion of cancer should begin treatment within 62 days of receipt of referral.[1] Dedicated fast track clinics with pre-booked appointments and scheduled investigations with rapid reporting can ensure urgent referrals are processed within appropriate timescales.[2] Hepatobiliary malignancy often presents with jaundice and therefore The Fast Track Jaundice clinic was established in NHS Grampian in June 2006.[3] Its aim was to provide rapid diagnosis of jaundiced patients enabling early management or treatment. This protocol driven clinic is run by the Hepatology Nurse Specialist with medical support. Referrals are faxed and patients who meet the criteria for the clinic are contacted by telephone and given an appointment date and time within a week of referral. The clinic operates weekly with three reserved appointment slots for ultrasound and two for CT scan. Endoscopic Retrograde Cholangiopancreatography (ERCP) is available three times per week.
Aim The aims of this study were: To describe the demographics and diagnoses of patients referred with jaundice. To assess the time from referral to treatment in patients presenting with malignancy.
Method The information was obtained from the NHS Grampian Fast Track Jaundice clinic Microsoft Access database and the hospital Patient Management System (PMS). The Scottish Care Information (SCI) store and hospital LABS system were accessed to obtain dates of investigations and results.
Results In total there were 172 referrals and all but one attended. The majority, 150 (87%) were referred by their GP, the remainder came from a variety of sources. The number of referrals has increased each year. The mean age at date of clinic appointment was 63 years (range 18–94, SD 16.7) and 116 (67%) were male. The median number of days from referral to clinic appointment was 5 (range 0–20, IQR 2). The reasons that patients waited longer than expected for a clinic appointment included: patient choice, inability to contact the patient and lack of capacity at next clinic. The aetiology of jaundice was: gallstones 65 (38%), malignancy 50 (29%), alcohol hepatitis 19 (11%), or an alternative diagnosis in 37 (22%). A CT scan was required for diagnostic or staging purposes in 90 (53%) with 74 (82%) of CT scans performed on the same day as the clinic. The CT scan had been performed prior to the clinic in 2 (2%) with the remaining scans occurring sometime following clinic.

Of the 50 patients with a malignancy, 13 (26%) had surgery with only 2 operations being outwith the 62-day timeframe (median time from clinic 36 days (range 4–99, IQR 38)). Of the remaining 37 (74%) who did not have surgery, 23 (62%) had ERCP (median time from clinic 3 days (range 1–38, IQR 7)) and 6 (16%) had PTC (mean time from clinic 9 days (range 4–16, SD 4.32)). The remaining 8 (22%) presented with such advanced disease that only palliative care was offered. Of those with malignancy 33/50 (66%) have died with a median time from clinic to death of 127 days (range 5–781 IQR 344).
Conclusion The introduction of The Fast Track Jaundice Clinic has resulted in patients with malignancy having clinical review and investigations performed rapidly with >95% receiving definitive treatment within 62 days of referral. The recognition of this service in providing timely, appropriate care has resulted in a steady increase in the number of referrals. We suggest that this model of service delivery should be considered as the standard of care for patients with suspected hepatobiliary malignancy presenting with jaundice.

REFERENCES

1. **Our National Health Cancer Access Targets. 2010**. http://scotland.gov.uk/Topics/Health/health/cancer/waiting-times (accessed 9 May 2011).
2. **Cancer in Scotland Sustaining Change. 2004**. http://www.scotland.gov.uk/Resource/Doc/25954/0013325.pdf (accessed 9 May 2011).
3. **Mitchell J,** Hussaini H. The jaundice hotline for the rapid assessment of patients with jaundice. *BMJ*; 325:213–15.

P41 LIVER DISEASE-SPECIFIC GENE EXPRESSION PROFILE IN HEPATOCELLULAR CARCINOMA

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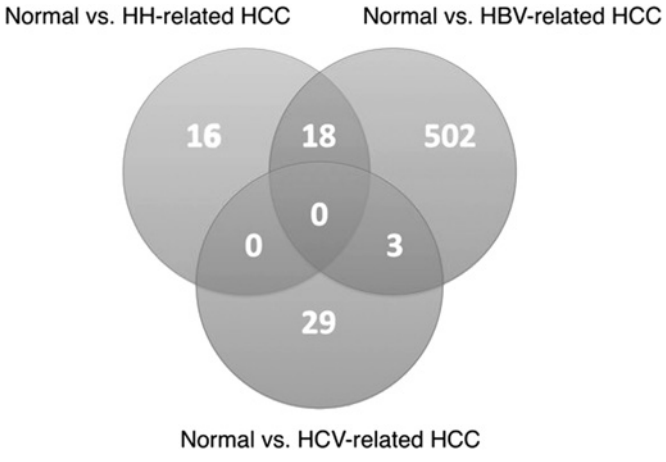
Introduction In the UK, hepatocellular carcinoma (HCC) has the largest increase in cancer mortality of all cancers over the last decade. Although it is well known that the most important risk factor for HCC development is liver cirrhosis, the specific role of liver disease aetiology in promoting cancer development remains under-explored. We hypothesised that different liver diseases might drive HCC development by expression of different sets of genes. Identification of liver disease-specific genes could be applied to developing disease-specific diagnostic markers or therapeutic targets.
Aim To compare global gene expression profiles from HCC arising in different liver diseases, using our own and publicly available data.
Method Fresh-frozen liver samples were collected from normal liver (4) and both background liver (7) and HCC (7) from patients with haemochromatosis (HH) undergoing liver transplantation or resection for HCC. RNA was extracted using a phenol-chloroform method, assessed for quality then hybridised to Affymetrix



Abstract P41 Figure 1 Venn diagram showing number of differentially expressed genes in HCV, HBV and HH related HCC compared to normal liver.