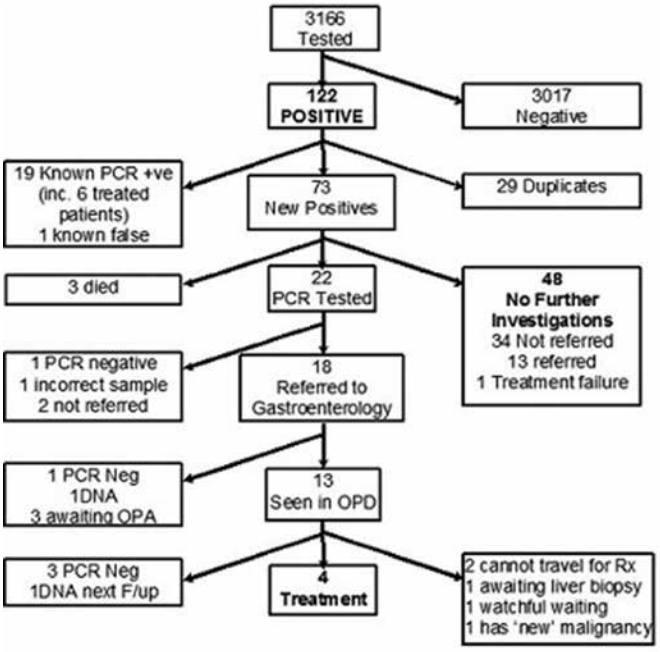
HCV antibodies requested, 49 (40%) were already known about. Of the remaining 73, 48 (66%) had no further investigation requested. Of these 48, 34 were not referred or investigated further (15 from primary care, 13 from secondary care, 6 from prisons). 13 were referred without PCR result, 11 did not attend (DNA'd) at first (6) or second (5) appointments, 2 have appointments outstanding and 1 had previously failed treatment but was not re-referred.



Abstract PWE-108 Figure 1

Conclusion The Hepatitis C action plan has failed to deliver. This audit demonstrates almost half the serology tests are unnecessary repeats, 2/3rd of true new positives never progress down the management pathway and only 3% access treatment.

Disclosure of Interest None Declared.

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PWE-119 HOSPITAL ADMISSION AND IN-HOSPITAL DEATHS FROM ALCOHOLIC LIVER DISEASE IN ENGLAND: ANALYSIS OF HOSPITAL EPISODE STATISTICS DATA

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Introduction Alcohol consumption is the third greatest risk factor for global disease, attributing to almost 4% of all deaths worldwide. Alcoholic liver disease (ALD) is one of the major causes of morbidity and mortality associated with long term high alcohol consumption. ALD is an ever increasing problem in England as previous studies have shown. However, little information exists on the trend of emergency admissions and the subsequent in-hospital mortality due to ALD.

Methods We carried out a retrospective analysis of emergency hospital admissions and in-hospital mortality for ALD in all NHS acute care hospitals in England between 2008/2009 and 2011/2012 using National Health Service (NHS) Hospital Episode Statistics (HES) data. We examined the variation in admission and mortality by age, gender and Strategic Health Authority (SHA) in England. HES data are coded using ICD 10 which gives ALD a code of K70.

Results Over the four study year period overall emergency admissions due to ALD increased by 9%; from 17.40 per 100,000 to 18.98 per 100,000 populations. The largest increase in admission was observed for alcoholic hepatic failure with a 44.43% increase. In-hospital mortality from ALD decreased by 9.3% between 2008/09 and 2011/12 from 229.99 deaths to 208.50 deaths per 1,000 ALD emergency admissions. Male mortality was lower than female mortality with male mortality also having a higher decrease of 10.6% compared to 7.3% in females. The rate of mortality differed across age groups peaking in 75–84 year olds, however most age groups saw a decline in mortality rate with 35–44 year olds seeing the greatest decrease of 15.5%. Standardised mortality from ALD also varied by region with the highest mortality found in the West Midlands and on the South East Coast and lowest in London and The North East.

Conclusion ALD related emergency admission rates are still on the increase although not at the same rate as reported in previous studies conducted in the UK. Reduced in-hospital mortality for ALD over the years suggests that hospital care for ALD patients is improving. Continued attention and effort are required to a greater extent to reduce the deaths from ALD.

Disclosure of Interest None Declared.

PWE-120 LIVER BIOPSY USING 16 G NEEDLE: A COMPARATIVE STUDY

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Introduction Liver biopsy is considered gold standard tool to investigate liver disease and provides valuable information which guides management[1].Currently most liver biopsies in UK are performed under ultrasound guidance using size 18 guage needles but the adequacy of biopsy specimen varies and sometimes suboptimal. The British Royal College of Pathologists recommend a specimen size of at least 1 cm and a minimum of 6 portal tracts [2], whereas the AASLD guidelines recommend a biopsy length of 2 cm, a minimum of 11 portal tracts for histological diagnosis and using 16 guage needle.[3]

Methods Retrospective data from ultrasound guided liver biopsies performed in 2011 using 16 gauge co -axial biopsy needle was collected from radiology and pathology databases. Adequacy of biopsy specimen, diagnostic and complication rates were analysed and results compared to a similar group of patients in 18 gauge group at a tertiary centre in London.

Results 50 biopsies (n = 50)compared from both groups. Mean age 48 years (range 24–85).56% were females (n = 28).Indications were chronic hepatitis B (n = 20), chronic hepatitis C (n = 9), NASH (n = 5), focal liver lesions (n = 5), haemochromotosis (n = 2), PBC/AIH (n = 2) and others (n = 7).All biopsies were performed by radiology fellows or consultants.90%were non-targeted (n = 45) and majority were taken from the right lobe. The mean number of cores obtained in 16 gauge group were 2.08(range 1–5) as compared to 1.46 (range 1–4) in 18 gauge group. The mean length of specimen in the 16 gauge group was 14 mm and the mean (±SD) number of portal tracts per biopsy were 15 (±8.145) as compared to 7.5 (±4.47)in the 18G group ($p < 0.001$). The specimen was diagnostic in 96% in 16 gauge group as compared to 90% in 18 gauge group.5 patients had metastatic lesions and were excluded from analysis. There were no major complications in either groups and one patient in the 16 G group died due to underlying metastatic cancer within 30 days of biopsy.

Conclusion Liver biopsy performed using 16 gauge co-axial needle improves specimen quality and increases diagnosis rate significantly