**Introduction** The relationship between development of ALD (which affects only 10–15% of heavy drinkers) and rate, duration and age of onset of alcohol consumption is incompletely understood. We have previously reported on total lifetime alcohol consumption in two cohorts of heavy drinkers (> 60 Units/wk(M) or > 40 Units/wk(F) for ≥ 5 years): one (patients) with uncompensated ALD (Child Grade B or C, negative tests for other liver diseases) and one (controls) without serious liver disease on clinical, laboratory and ultrasound examination. Here, we aimed to compare alcohol consumption patterns in these cohorts in more detail.

**Methods** Subjects (330 patients, 234 male, mean age 48 yr and 285 heavy-drinking controls, 187 male, mean age 48 yr) completed a lifetime alcohol questionnaire. Alcohol consumption was calculated at home and outside home, and during Monday-Thursday and Friday-Sunday. Data were summed over each stable drinking period during the subject’s lifetime. We calculated (a) total duration, and age at start and at cessation of all periods during which the subject drank > 0, > 40, > 80, > 120 and > 160 units(U)/wk and (b) percent of drinking career engaged in: regular drinking, drinking < 5 days per week, weekend drinking and not drinking.

**Results**

**Abstract PTU-100 Table**

<table>
<thead>
<tr>
<th>Units/wk</th>
<th>Duration (yr)*</th>
<th>Age started/yr)*</th>
<th>Duration (yr)</th>
<th>Age started (yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 0</td>
<td>30 (23–36)</td>
<td>17 (16–18)+</td>
<td>30 (23–36)</td>
<td>16 (15–18)</td>
</tr>
<tr>
<td>&gt; 40</td>
<td>20 (14–27)</td>
<td>22 (18–30)+</td>
<td>22 (16–30)</td>
<td>19 (17–25)</td>
</tr>
<tr>
<td>&gt; 80</td>
<td>12 (6–19)</td>
<td>29 (21–38)+</td>
<td>13 (7–22)</td>
<td>25 (18–33)</td>
</tr>
<tr>
<td>&gt; 120</td>
<td>3 (0–12)</td>
<td>32 (24–41)+</td>
<td>4 (0–10)</td>
<td>28 (21–37)</td>
</tr>
<tr>
<td>&gt; 160</td>
<td>0 (0–7)</td>
<td>33 (27–41)+</td>
<td>0 (0–7)</td>
<td>30 (24–39)</td>
</tr>
</tbody>
</table>

* median (interquartile range). +: p < 0.001, +: p = 0.02, ++: p = 0.017 by Mann-Whitney test for patients vs controls.

Neither total duration of periods consuming > 0, > 40, > 80, > 120, and > 160 U alcohol/wk (table) mean weekly consumption during those periods (not shown) differed significantly between patients and controls. However, patients first started drinking over each level at an older age than did controls (table). The relationships between ALD and age of starting drinking > 0, > 40, > 80, > 120 and > 160 U/week persisted in multivariate analysis (p = 0.00–0.015). Subjects spent S5(63–97)% of their careers in regular drinking, with no case-control differences.

**Conclusion** Development of decompensated ALD in heavy drinkers is associated with starting heavy drinking at an older age.

**Disclosure of Interest** None Declared.
the ascitic fluid samples sent to our microbiology department. Case notes for these patients were reviewed and data were collected on patient demographics, aetiology of cirrhosis, use of blood products and human albumin solution (HAS) and volume of ascites drained.

Results 86 LVP were performed on 28 patients. 24 were male, age range 30 – 84 years (median 59 years). Alcohol was either the only or a contributory cause of cirrhosis in 25 (89%) of patients. None had hepatitis B or C virus infection.

5 patients received fresh frozen plasma (14 units in total) and 1 received octaplex® prior to LVP. The total cost was £1024.

8 patients had less than 5L ascites drained and received a total of 19 units of 20% HAS. 16 patients received more than 8g albumin per litre of ascites drained (a total of 31 unnecessary units). The total cost of this was £1400.

The potential cost saving per procedure was £49.47. However data on albumin administration was unavailable for 7 patients and this could be an underestimate.

Conclusion Alcohol is the predominant cause of cirrhosis requiring LVP in our population and working age men constitute the largest proportion. Significant cost savings can be made by avoiding unnecessary blood products and by avoiding excessive use of albumin or administering other fluids when less than 5 litres of ascites are drained. Trusts should ensure relevant protocols are in place.

Disclosure of Interest None Declared

REFERENCE

PTU-103 AUDIT INTO THE MANAGEMENT OF ACUTE VARICEAL BLEEDS AND THE ROLE OF TIPS
doi:10.1136/gutjnl-2013-304907.193

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Introduction The mortality associated with acute variceal bleeding is significant with a 70% risk of recurrent haemorrhage in survivors. Our aim was to assess the outcome from variceal bleeding at St George’s Hospital over a one year period, to determine whether current clinical guidelines in the management of variceal bleeding are being adhered to, and to assess whether we are utilising the role for early TIPS (transjugular intrahepatic portosystemic shunt) in patients with variceal bleeding.

Methods A dataset of all adult patients admitted from 1/4/11 for a period of 12 months was obtained with a primary diagnosis code of K922 Gastrointestinal haemorrhage, unspecified (n = 378). Genuine cases were confirmed by reference to the Micromed endoscopy reporting tool, CEPOD emergency theatre lists, bereavement notes for these patients were reviewed and data were collected on the ascitic fluid samples sent to our microbiology department. Case notes were obtained for the final sample of 23 patients.

Results The main cause of variceal bleeding (65%) was alcoholic liver disease (ALD). 78% were rebleeds of which 83% were within the last 6 months. 61% of patients had features of decompensation (ascites 86%, renal dysfunction 29%). Only 4% of cases were Childs-Pugh A, with 61% of cases being Childs-Pugh B and 35% Childs-Pugh C. The predicted 3 month mortality according to the MELD model for end stage liver disease score was 6–19.6%. An average of 2 to 3 units of blood was transfused to 78% of patients and 60% of patients required either FPP, platelets or both. All patient received an endoscopy during their admission, of which 74% were carried out within 12 hours. Only 52% were intubated for procedure and 59% were admitted to ITU post procedure. 96% received antibiotics, 87% received terlipressin and 79% were discharged on propranolol. Only 35% of patients received succral-fate post banding.

Only 13% of patients had a TIPS procedure. A further 48% of our sample could have been considered for TIPS where no contra-indication was found (i.e hepatic encephalopathy not secondary to UGI bleeding or renal dysfunction). The average length of stay was 14 days and the 30 day mortality rate was 13%.

Conclusion The pharmacological management was generally good and our mortality rate of 13% was better than the quoted figures of 30% in the literature. However, we identified a possible 48% of the sample could have been considered for TIPS which is no longer considered rescue therapy alone with good evidence for its early use, with subsequent prevention of readmission from a variceal bleed.

We recommend early pharmacotherapy with terlipressin and antibiotics as soon as varices are suspected with early ITU involvement, airway protection at endoscopy and early TIPS in selected patients.

Disclosure of Interest None Declared.

STILL ABSCESSES: SURPRISINGLY POOR BUT MORTALITY STILL LOW
doi:10.1136/gutjnl-2013-304907.194

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Introduction Untreated, pyogenic liver abscesses have a mortality approaching 100%. Three admissions in a week sparked interest in the best management of this condition. Although common, no comprehensive management guidelines could be found, prompting further review into how well this condition was managed locally.

Methods Retrospective analysis of all patients admitted to Watford Hospital between 2006 and 2011 with a diagnosis of pyogenic liver abscesses. Data was collected to evaluate use of cultures, radiological intervention (aspiration or drain insertion), source of infection, investigation for cause, follow up and outcome.

Results Forty four admissions were identified: 39 patients with 5 re-admissions. Mean age was 62 yrs, 59% male, 41% female. Eleven patients were managed by the Gastro team.

Assumption of source was made on CT imaging results: 46% presumed portal translocation (most diverticular disease), 36% biliary, 18% unidentified. Blood cultures were taken in 24 patients (42% positive). Abscess aspirates were taken in 33 cases, sent for culture in 30 (50% positive). Presumed biliary or unidentified sources grew gramme negative organisms in 12/13 cases. Presumed portal sources grew gramme positives in 7/8 and anaerobes 1/8.

Abscess size was < 3 cm in 5 cases (incl. 2 re-admissions). Four received antibiotic (ABC) alone: resolution in 3/4, 1/4 no follow up. One was managed to resolution with ABC and aspiration. Mean length of stay was 11 days.

In 6 patients the abscess was 3–5 cm. In this group, 1 patient with malignancy died, 1 treated successfully with ABC alone. The remaining 4 were treated with ABC and aspiration: 1/4 resolution, 1/4 readmitted, 2/4 no follow up. Mean length of stay was 15 days.

Thirty three patients had abscesses > 5 cm (incl. 3 re-admissions). Nineteen were treated with ABC and drainage: 2/19 had underlying malignancy and died, 6/19 resolution, 3/19 readmitted, 7/19 no follow up, 1/19 referred to surgery. Of the remaining fourteen, 3/14 had ABC alone (2 resolved, 1 patient with two re-admissions no follow up), 1/14 a readmission referred for surgery and 10/14 ABC and aspiration. Outcome in these ten: 1/10 multiple aspiration, 2/10 drain insertion, 1/10 surgical referral, 1/10 readmitted, 1/10 partial response, 3/10 no follow up, 1/10 resolution. Mean length of stay in > 5 cm group : 27 days.
PTU-102 Alcoholic Liver Disease in working age men constitutes the main burden of Large Volume Paracentesis (LVP) in Devon and significant cost savings are possible

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