

Methods The aim of the study was to compare demographics, treatments and survival among hepatitis C virus (HCV/HCC) and NAFLD (NAFLD/HCC) cohort of patients. Data were collected from medical electronic case notes, imaging reports and HCC multidisciplinary meetings.

Results Among 292 patients, 212 patients (73%) had underlying HCV/HCC and 80 patients (27%) had NAFLD/HCC. The median age at diagnosis was significantly higher in NAFLD/HCC ($p < 0.001$). The majority (82%) were male. Body mass index (BMI) was significantly higher in NAFLD/HCC ($p < 0.001$). The majority were Caucasian (96%) in NAFLD/HCC, whilst the HCV/HCC cohort was significantly more ethnically diverse ($p < 0.001$). Diabetes mellitus was more common in NAFLD/HCC patients ($p < 0.001$).

The median alpha fetoprotein level in HCV/HCC patients were 32.0 compared to 12.0 in NAFLD/HCC ($p = 0.085$). Patients with HCV/HCC were significantly more likely to be transplanted during the study period than NAFLD/HCC (30% vs. 15%, $p = 0.010$). Both transarterial chemoembolization (TACE) and percutaneous ethanol injection (PEI) were significantly more likely to be used as a single treatment in NAFLD patients, compared to HCV patients ($p = 0.042$, $p = 0.021$). Sorafenib was used as the only treatment in 6% of HCV/HCC and 3% of NAFLD/HCC cohorts ($p = 0.364$). Post transplant survival appeared to be worse in HCV-HCC patients compared to NAFLD/HCC, although it did not reach statistical significance ($p = 0.081$). Overall five year survival rates were similar between the two groups regardless of any treatment therapies ($p = 0.424$).

Conclusion Despite the NAFLD/HCC being older and with higher metabolic risk factors, a significant proportion could undergo active therapy. Furthermore, patients with NAFLD/HCC selected for transplantation seemed to have better long term outcomes, possibly due to stricter selection for transplantation as well as variations in tumour biology between the two groups.

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Disclosure of Interest None Declared.

PTH-087 PERCEPTIONS OF LIVER DISEASE AMONGST THE NEPALI COMMUNITY; DESIGNING EFFECTIVE CASE-FINDING STRATEGIES TO TEST UK MIGRANT GROUPS FOR HBV AND HCV

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10.1136/gutjnl-2014-307263.533

Introduction Identifying at-risk migrant groups for Hepatitis B and C (HBV and HCV) is well established. The UK Nepali community has grown rapidly since 2004, when settlement rights were given for ex-Gurkha servicemen and dependants. Given military associations, the Hampshire County now has the second largest Nepali population, with the Nepali now making up close

to 10% of the population. Nepal sits between China and India, two countries with higher prevalence rates of HBV and HCV, but relatively little is known about prevalence in the Nepali community, with no published studies in the UK.

Methods To help design a culturally sensitive testing strategy for HBV and HCV (as advocated by NICE) we conducted focus groups sessions in the Nepali community. Nepali moderators guided sessions to study the beliefs, understanding and perceptions towards liver disease.

Results 32 Nepali members attended the focus group sessions, with groups divided by sex and age (< 30yrs, or > 30 yrs). A thematic analysis approach was used to analyse results.

Perceptions of Liver disease:

“It is not a communicable disease”

“In Nepal water is the main cause of hepatitis”

“Mainly alcoholic and smokers get this disease”

“I do not think people hate the person....it would not be considered as bad as leprosy disease”

Treatment options:

“In Nepal herbal medicine is better for jaundice....necessary to drink lot of water and fruits”

Knowledge and outreach:

“We need to know the function of liver. Then we understand the issue.”

“Newspaper for the people who can read but for us who cannot read, radio and TV is better”

“What the doctor said, we trust on it”

Conclusion NICE guidelines advocate testing at-risk migrant groups for HBV and HCV at an early (asymptomatic) stage. Here, all groups identified liver disease with jaundice or symptoms. Different viewpoints were expressed based on age; younger Nepali members associating a greater stigma to liver disease and hepatitis. All groups expressed a sincere wish to gain greater knowledge about liver disease and to interact with primary care. The study also identified the functional illiteracy of many Nepali, and the potential need to modify approaches away from written media.

REFERENCE

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Disclosure of Interest None Declared.

PTH-088 NON INVASIVE MONITORING OF FATTY LIVERS IN MORBIDLY OBESE PATIENTS: PRELIMINARY EVALUATION WITH ACOUSTIC RADIATION FORCE IMPULSE IMAGING

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10.1136/gutjnl-2014-307263.534

Introduction Liver biopsy remains the gold standard for diagnosing non-alcoholic steatohepatitis (NASH). But with a variability of 10–20% and a mortality rate of 0.01%, non invasive techniques of monitoring change in liver morphology have been sought after. Acoustic radiation force impulse imaging (ARFI) is a promising innovation that combines ultrasound imaging and elastography to measure liver stiffness which correlates well with liver fibrosis. Morbidly obese patients are at a risk of developing NASH or Non Alcoholic Fatty Liver Disease (NAFLD) and weight loss helps improve liver steatosis. Very low calorie diets