

Introduction Anogenital granulomatosis (AGG) is a recently recognised cause of genital lymphoedema¹⁻³ an association of CD with AGG has been noted in previous case reports.^{1,3} It presents with genital erythema and swelling, and flares are frequently misdiagnosed as cellulitis. We present a large case series.

Methods Patients were identified from referrals to the regional to the Lymphoedema Service at St George's Hospital after failure of antibiotics and topical steroids to improve symptoms. Demographic, clinical and endoscopic finding were correlated in patients with histological features of AGG in patients.

Results Sixteen patients (15 male, 1 female; aged 34.8 ± 15.0 yr (mean ± s.d.)), were referred with AGG.

14 of 16 patients initially presented with genital swelling whilst 2 others presented with buttock swelling. Swelling of additional sites was noted in several patients (mons pubis – 25% of patients; natal cleft – 25%; peri-anally – 19%; buttocks – 12.5%). Although initially intermittent (15/16 patients), genital swelling was typically well established and irreversible by the time of presentation to the Lymphoedema Clinic. Flares involved erythema and deterioration of swelling which failed to return to baseline. Established swelling was associated with an increased risk of cellulitis in addition to the non-cellulitic flares.

Histological examination of the affected areas demonstrated dermal (and one case of intra-lymphatic) non-caseating granulomas in 12 patients with the remainder diagnosed clinically. Gastroenterology review, including colonoscopy, confirmed a diagnosis of Crohn's disease in 37.5% of patients.

Treatment of AGG has proven difficult. Initial treatment with compression garments and prednisolone showed a reduction (but not elimination) of scrotal and penile shaft swelling in 9/11 patients. Antibiotics reduced the frequency of flares in only 3/11 patients. Steroid-sparing immunosuppression was successful in 4/11 patients. In 6 patients, lymphoedema of the foreskin caused difficulties in micturition and therefore circumcision was successfully utilised to improve urinary flow. Debulking surgery has been used in only a small number of our cases to date.

Conclusion AGG should be considered in all patients (especially male) presenting with isolated genital lymphoedema and may unusually be the presenting feature of Crohn's disease. Early diagnosis allows for prompt initiation of systemic immunosuppression therapy which is currently the treatment of choice. We hypothesise that swelling is precipitated by non-infective granulomas blocking lymphatic vessels, research in this regard is in progress.

REFERENCES

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Disclosure of Interest None Declared.

PTU-109 AZATHIOPRINE IN THE ELDERLY – IS IT TOLERATED AND IS IT SAFE?

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Introduction The use of Azathioprine (AZA) for maintenance of remission in Inflammatory Bowel Disease (IBD) is common practice as part of national and international guidelines. Side effects however are common. Of 353 consecutive patients commencing AZA in our organisation, 36% were not taking it at one year.

With an ageing population, IBD is increasingly relevant in those over 75 years old. However there is little data concerning the efficacy and tolerability of AZA in this age group.

Methods We maintain a prospective database of IBD patients. All patients commenced on AZA between June 2005 and October 2012 over the age of 75 were identified. Thiopurine Methyl Transferase (TPMT) levels were checked in all patients and AZA was prescribed at 2–2.5 mg/kg, with 50% dose reduction in those with low TPMT. We monitor full blood count and LFTs weekly for 8 weeks after commencing therapy.

Results 25 patients were identified, (7 CD, 18 UC). The mean age at which AZA was started was 78 (range 75–86), 16 were male (64%). All patients were followed up for at least one year. 12 (48%) were intolerant of AZA. Reasons for stopping AZA were; hepatitis, 2 (8%); vomiting, 5 (10%); pancreatitis, 1 (4%); myelosuppression (1); joint pain (1); infection (1); and general malaise (1). The mean duration of AZA use in these patients was 34 days (Range 3–89). 13 (52%) tolerated the drug well with one of this group having the drug actively withdrawn at 701 days in complete clinical, endoscopic and histological remission. There were four deaths (16%). Two died in the group intolerant of AZA (84 year old died of stroke 888 days after 13 days of AZA; 82 year old died in the community 140 days after 5 days of AZA). Two people died in the AZA treated group (83 year old died in the community on day 1476 of AZA; 79 year old died following cardiac arrest on day 212 of AZA).

Conclusion Our data demonstrate that AZA is an effective treatment in the elderly. It appears to be less well tolerated than in the general population with 48% intolerant of the drug within 3 months. Within the limitations of this study it appears to be safe. The increased incidence of drug intolerance in this population group may suggest that low-dose azathioprine and allopurinol co-therapy should be considered first-line therapy in this group. A further study to clarify this is required.

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Liver I

PTU-110 REDUCTION IN SERUM SODIUM (NA) IN PATIENTS TREATED WITH TERLIPRESSIN FOR VARICIEAL BLEEDING (VB) AND HEPATORENAL SYNDROME (HRS)

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Introduction Terlipressin is used in the management of VB and HRS. Studies have suggested decrease in Na levels on terlipressin, usually in VB.

We set out to report the incidence of fall in serum Na in patients receiving terlipressin for VB or HRS.

Methods Consecutive patients admitted to Gwent Liver Unit who received terlipressin were identified. Main outcome measure was fall in Na level during and up to 5 days post therapy.

Results 60 patients were analysed (32 HRS, 28 VB). Median Na pre-treatment was 133 and 29/60 (48%) had existing hyponatraemia; 16 (27%) had Na <125mmol/l.

Na fell in 34/60 patients (57%) and was less likely if baseline hyponatraemia existed (38% VS 74% $p = 0.004$). A fall of $\geq 5\text{mmol/l}$ occurred in 23%.

Median time to nadir Na was 3 days and time to recovery to pre-treatment Na was 6.5 days. No complications of hyponatraemia were observed.

Patients with VB were more likely (vs HRS patients) to have any fall in Na or a $\geq 5\text{mmol/l}$ reduction (68% vs 47% $p = 0.1$ and 32% vs 16% $p = 0.12$ respectively) but failed to reach significance.

Mortality was 22% overall and a fall in Na was actually associated with reduced mortality –9% vs 34% ($p = 0.01$).

Conclusion Serum Na falls in >50% receiving terlipressin and a fall $\geq 5\text{mmol/l}$ noted in 23%.

However, no significant complications occurred and a fall in serum Na was actually associated with improved mortality. Patients with VB treated with terlipressin trended towards a greater likelihood of Na reduction versus those with HRS.

Disclosure of Interest None Declared.

PTU-111 DETERMINING CEILING OF CARE IN DECOMPENSATED CIRRHOSIS – RIGHT DECISIONS, RIGHT PEOPLE, RIGHT TIME

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Introduction Decisions to initiate intensive care measures in patients with decompensated liver cirrhosis are often controversial, with mortality approaching 90% in cirrhotics with 3 organ failure. The 2013 NCEPOD report ‘Measuring the Units’, which examined alcoholic liver disease-related deaths, nonetheless found that 31% of those who stood to benefit from higher level care did not receive it. We studied escalation of care decisions and subsequent outcomes in cirrhotic patients with organ failure.

Methods Consecutive patients with a diagnosis of cirrhosis admitted over a 90 day period in 2013 to the Bristol Royal Infirmary were studied. Severity of liver disease was assessed using Childs-Pugh and UKELD. Organ failure was defined using SOFA (Sequential Organ Failure Assessment) criteria. Care escalation/withdrawal decisions were assessed in respect to timing, seniority and expertise of decision maker. Outcome measures of ICU admission, mortality and instigation of palliative care were recorded.

Results 42 admissions for 37 patients (ages 16–79, 79% male, 81% related to alcohol, 22% Childs A, 54% Childs B, 24% Childs C) were scrutinised. 30% had suffered variceal haemorrhage on, or during, admission. Of 17 patients admitted in organ failure, ICU admission was requested on 8 occasions (6 by a hepatologist, 1 during out of hours admission, 1 following out of hours deterioration). Escalation plans had been discussed with ICU prior to the point of clinical deterioration in 50%. 3 patients were accepted to ICU for mechanical ventilation, of which none survived. 1 patient was accepted in principle but improved clinically. 4 patients were declined ICU admission on grounds of poor prognosis, all of whom had alcoholic cirrhosis. Of this group all required non-invasive ventilation, with 75% surviving to discharge. Across the entire cohort 55% of hepatologist led “for full escalation if required” decisions were agreed in principle with ICU. 33% of ICU decisions to withdraw care were discussed with the referring hepatologist. Of the 7 patients who died overall, 4 were on an end of life tool with appropriate palliative measures in place.

Conclusion The high survival rates in patients refused intensive care, and high mortality amongst mechanically ventilated

patients highlight the complexities of predicting outcomes in this population. Despite this, discussions between hepatology and ICU regarding ceiling and withdrawal of care often did not occur until the point of clinical deterioration, risking delays to escalation of care or appropriate palliation. Strategies to ensure early escalation decisions involving senior hepatologists and intensivists should be developed to ensure appropriate care is afforded to all cirrhotic patients in a timely fashion.

Disclosure of Interest None Declared.

PTU-112 ASSOCIATIONS BETWEEN HEALTHCARE RESOURCE UTILISATION AND HEALTH-RELATED QUALITY OF LIFE IN CIRRHOSIS

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Introduction Cirrhosis is associated with impaired Health-Related Quality of Life (HRQoL) and considerable resource use. The association between healthcare utilisation and HRQoL in cirrhosis has not been previously studied.

Methods Four HRQoL tools (SF-36v2, CLDQ, PBC-40 and PROMIS-HAQ) and a healthcare utilisation tool were completed by patients with cirrhosis. Associations between resource utilisation and HRQoL were explored; means were compared using unpaired t tests.

Results 108 patients have been recruited to the study to date with completed tools received from 73. Regular care was required by 29 (40%) with 15 (21%) requiring help with personal care, 12 (16%) with medical care, 18 (25%) with meal preparation and 21 (29%) with housework. All types of care were associated with significantly impaired HRQoL across all domains of all measures tested ($p < 0.05$). The total number of healthcare consultations (hospital consultations + GP consultations + nurse consultations) was also related to HRQoL with patients who had five or more consultations in a 2 month period showing significant impairment compared to patients with fewer than five consultations. Specifically there was evidence of poorer physical HRQoL with mean SF-36 Physical Component Summary (PCS): 32.5 ± 9.0 vs 40.6 ± 10.6 , $p = 0.001$ and functional restriction evidenced by PROMIS-HAQ: 42.2 ± 26.9 vs 21.1 ± 25.2 , $p = 0.001$. In addition, patients with more consultations had poorer social HRQoL with SF-36 Social Functioning (SF): 31.3 ± 12.3 vs 40.2 ± 12.8 , $p = 0.005$ and PBC-40 social: 36.3 ± 9.9 vs 30.0 ± 9.7 $p = 0.01$.

Conclusion The need for any type of regular care and more frequent consultations with healthcare professionals are associated with poorer HRQoL in cirrhosis.

Disclosure of Interest None Declared.

PTU-113 A REGIONAL AUDIT OF THE MANAGEMENT OF PATIENTS WITH DECOMPENSATED LIVER DISEASE

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Introduction The recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report ‘Measuring the Units’ found that hospitals are missing opportunities to save the