Introduction Outpatient visits to secondary care are costly to Primary Care (PC), time consuming for patients and not always appropriate. Our Trust having been a pioneer in nephrology e-Consultation (eC), we started a hepatology eC service in March 2012. This allows patients' records to be shared between PC and secondary care (SC) without the need for a detailed referral letter.

Our aims were to analyse our initial experience and perform a cost analysis of hepatology eC.

Methods Retrospective analysis of eC between Mar 12- Oct 13 using SystmOne. Tariffs used for cost analysis: new patient (NP) referral £181, follow up (FU) £103, **eC £24.**

Results In 18 months there were 81 eC (31M/50F mean age 52/56 y), each taking 10–15 min to complete. The median response time was 2 days (43% within 1 day). Referral reasons: isolated raised bilirubin/ALT/ALP/GGT: 44/81 (54%), mixed raised LFT's: 16/81 (20%), abnormal radiology 10%, hyperferritinaemia 9%, HBV/HCV 4%, general advice 2%. There was one inappropriate referral. In 18 cases, SC referral was recommended (22%), with 10/18 being referred and seen. The mean number of FU appointments was 3. Total cost to PC was £8,114: eC £1,944 and £6,170 for subsequent referrals. A minimum cost saving of £14,890 was made (81 NP (£14,661) and assuming one FU for each (£8,343)).

Conclusion eC is a rapid, cost-effective method of providing hepatology advice. Hidden costs including consultant time, clinic costs etc are difficult to quantify. We would, however, recommend eC as the way forward with a more appropriate tariff.

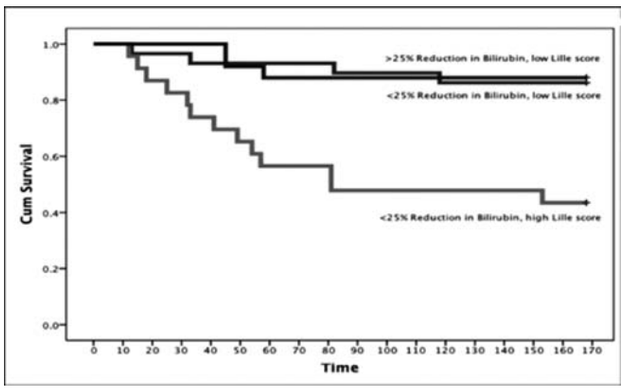
Disclosure of Interest None Declared.

PTU-133 PREDICTING MORTALITY IN ALCHOLIC HEPATITIS; A COMPARISON IN DIFFERENT SCORING SYSTEMS

SK Sidhu*, C Reddick, A Turner, K Mcwhirter, A Al-Rifai. *Salford Royal Hospital, Manchester, UK*

10.1136/gutjnl-2014-307263.207

Introduction Alcoholic hepatitis is a severe presentation of alcoholic liver disease. In its most severe form (with a Maddray score >32) the 1 month mortality is 35%. There are currently a few methods used to decide if continuation of corticosteroid therapy is beneficial, the Lille's Score and the presence of a 25% reduction in the serum bilirubin between day 1 and day 7. We assess the effectiveness of these scoring systems in assessing 6 month mortality.



Abstract PTU-133 Figure 1 Kaplan-Meier survival curve at 6 months post admission

Methods All patients admitted with a diagnosis of alcoholic hepatitis with a Maddray score > 32 with no evidence of sepsis over a 2 year period (2010–2012) were identified. All the notes were analysed and data collected by a F1 using a standardised profroma. Patients were placed into 4 groups: Group 1= <25% reduction in bilirubin, low Lille score, Group 2= <25% in bilirubin, high Lille score, Group 3= >25% reduction in bilirubin, low Lille score and Group 4= >25% reduction in bilirubin, high Lille score.

Results Overall 77 patients were included, at 6 months 21 died (27%). The mean age was 48 yrs (Range 27–67 years). At day 1 there was biochemical parameters consistent with significant liver disease (Madray Score: 68 (Range 34–169), Albumin 29.9 ± 4.9, INR: 2.0 ± 0.5, Bilirubin: 235 ± 135). 77 (100%) patients received nutritional support, Vitamin B and Thiamine. The baseline INR (Alive: 1.85 ± 0.47, Died: 2.31 ± 0.59 p = 0.001) and Albumin (Alive: 30.6 ± 4.6, Died: 28.1 ± 5.5 p = 0.04) were significantly deranged in patients who died at 6 months. There was no significant difference in the baseline Urea (Alive: 3.81 ± 3.54, Died: 4.26 ± 3.46 p = 0.610), Creatinine (Alive: 64.3 ± 45.9, Died: 79.5 ± 59.6 p = 0.232) and Bilirubin (Alive: 237.8 ± 144.6, Died: 228.1 ± 110.3 p = 0.779) in patients who died at 6 months.

There were no patient that fell into group 4. In the other 3 groups there were similar numbers of patients (Group 1: 29 patients, 6 month mortality 17%, Group 2: 23 patients, 6 month mortality 57%, Group 3: 25 patients, 6 month mortality 12%). Kaplan Meier survival curves were created for these 3 groups and is shown in Figure 1 below.

Conclusion In this study factors suggesting poor liver synthetic function (INR and Albumin) were associated with 6 month mortality. There was a significantly worse outcome with a high Lille score compared to a low Lille score. There was very little effect of a greater than 25% reduction in bilirubin on mortality at 6 months. From this study we would suggest that the Lille score is used to accurately predict a poor outcome.

Disclosure of Interest None Declared.

PTU-134 DURHAM PATHWAY FOR CARE OF PATIENTS WITH ADVANCE STAGE LIVER DISEASE (ASLD)

[1]S Saksena*, [2]L Hammal, [2]M Hewett, [2]C Lancaster. *[1]Hepatology, Durham, UK; [2]County Durham Darlington Foundation Trust, Durham, UK*

10.1136/gutjnl-2014-307263.208

Introduction Care of patients with ASLD is poorly organised. This service improvement project aimed to develop a consistent pathway of care for ASLD patients.

Methods Methods and results were iterative and included: 1. Track patient journey and Carer Experience: 2. Capture Activity Data from Clinical Coding: 3. Process mapping patient journey and Identify gaps in service provision 4. Design "Durham pathway" Figure for improving care of patients with ASLD with in reach liver service in community and developed range of both quantitative and qualitative metrics "Durham metrics" to monitor the effectiveness of the new pathway on patient outcomes and experience. 5. Engage relevant stakeholders and shared pathway 6. A 6 month Pilot of 20 ASLD patients with Community matron led inreach service. 7. Engage commissioners to fund ASLD pathway.

Results Pre-pilot patient and carer experience was poor with multiple unplanned admissions, preferred place of death was not discussed, majority of deaths in hospital, care was not