transplanted since the “alcohol contract” was implemented (February 2007) and 68 patients transplanted before.

Results Overall (n=100; 62 male, median age 54), 37 patients reported some alcohol intake post-OLT. The proportion of patients returning to any alcohol was 35.3% before the “alcohol contract” and 40.6% after (NS; p=0.66). For heavy drinking (>21 units [168 g ethanol]/week) this was 16.2% and 15.6%, respectively (NS; p=1.0). Four patients underwent OLT despite pre-transplant liver histology consistent with active ALD. After OLT, one of these returned to heavy drinking and another denied drinking but had a positive blood alcohol. At explant, 10 patients had features of active ALD: six of these returned to drinking post-OLT. Blood alcohol was measured in only 24 of 63 patients reporting abstinence. Two had positive tests; one of these subsequently disclosed heavy drinking. During follow-up, 23 patients died. Most deaths (87%) occurred in those (63%) who did not return to drinking. Only one death in 673 patient-years of follow-up could be directly attributed to alcohol intake.

Conclusion Post-OLT recidivism is higher in our cohort than other published series but the impact of drinking on post-transplant survival remained low. The introduction of an “alcohol contract” may have value in improving public perception of transplantation in ALD patients but is insufficient to alter rates of recidivism. Random blood alcohol testing is inadequate to detect post-transplant drinking. More robust abstinence support and better assessment measures might improve outcomes.

Abstract PTU-066 Figure 1

Competing interests None declared.

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PTU-067

OUT-PATIENT ASSESSMENT FOR LIVER TRANSPLANTATION: A SINGLE CENTRE EXPERIENCE

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Introduction Assessment for orthotopic liver transplantation (LT) traditionally requires admission to hospital. In 2010, the liver unit at the University Hospital Birmingham (UHB) launched the first UK-based out-patient assessment programme (OPA). This study aims to describe our experience, with specific focus on feasibility, efficacy, cost-effectiveness and patient satisfaction.

Methods Patients undergoing elective LT assessment were retrospectively analysed between June 2010 and April 2011. Data

collected included patient demographics/clinical features, LT assessment parameters, duration to listing/LT and reasons for LT refusal. An extensive cost evaluation was performed on both in- and out-patient LT assessment, including clinical tests, staffing and hospital facilities utilised. Patient satisfaction questionnaires were collected prospectively from April 2011 to November 2011.

Results 179 patients underwent LT assessment. 87/94 successfully completed OPA, with seven converted to in-patient LT assessment (IPA) due to pre-existing co-morbidity including refractory ascites and hepatic encephalopathy. All patients referred for OPA were triaged 2 weeks prior to the assessment to ensure suitability. 92 patients successfully underwent IPA. 66/87 OPAs were subsequently listed for LT (median duration from OPA to listing 3 days [0–306], of which 37/66 received a cadaveric graft. The reasons for OPAs not listed include: too early for LT (50.0%), contraindication to LT (42.9%) and patient refusal (7.1%). 53/92 IPAs were listed, mean duration 4 days [1–39], of which 34/53 were transplanted. Reasons for IPAs not listed: contraindication to LT (48.2%), too early for LT (44.4%) and patient refusal (7.4%). A single IPA costs on average £14441 as compared to £11494 for an OPA. Overall satisfaction (mean score 9.6/10; 10=very satisfied, 1=very dissatisfied) and convenience (7.9/10) for patients undergoing OPA were high.

Conclusion We describe for first time that OPA is feasible, efficient and cost-effective. With increasing demand on hospital beds in the UK National Health Service, such a programme has the potential to reduce the burden on LT in-patient services.

Abstract PTU-067 Table 1 Patient demographics and clinical features

	OPA (n=87)	IPA (n=92)
Mean age (±SD)	52.3 (±1.3)	55.0 (±0.9)
Male sex (%)	58.6	54.3
Aetiology		
Viral	6	11
Alcohol	6	21
HCC	26	12
Metabolic	9	20
Autoimmune/biliary	30	13
Other	10	15
UKELD median [range]	51 [43–66]	53 [43–67]
Liver co-morbidities		
Encephalopathy	23	40
Refractory ascites	0	7
Variceal bleeding	14	8
Other co-morbidities		
Hypertension	10	3
Diabetes	11	10
Renal impairment	1	4

Competing interests None declared.

Hepatobiliary I

PTU-068

BILIARY MATRIX METALLOPROTEINASE 9 LEVELS ARE INDEPENDENT OF NEUTROPHIL GELATINASE-ASSOCIATED LIPOCALIN IN PATIENTS WITH MALIGNANT BILIARY OBSTRUCTION

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