baseline, clinical data including alcohol and smoking history, BMI and features of portal hypertension were recorded. Laboratory data (bilirubin, creatinine, sodium, PT, INR and platelet count) were collected. On biopsy, the presence of cirrhosis and histological features (fat severity, lymphocyte and neutrophil infiltration) were scored semi-quantitatively.

Results Median age was 51 (29–67) and the majority (72%) were male. All patients had a history of alcohol excess (>80 g/day for men, 50 g/d for women). Patients were followed until death (n=97; median 62 m), OLT (n=5; median 96 m) or are still alive (n=32; median 187 m). Overall, the 5, 10 and 15-year survival was 64, 40 and 26%, respectively. Patient baseline characteristics are shown according to outcome (Abstract PWE-285 table 1). In multivariate analysis age (p=0.01), smoking (p=0.01), persistent drinking (p<0.01) and serum albumin at baseline (p=0.02) were associated with significantly increased risk of death. No histological features correlated with prognosis.

Abstract PWE-285 Table 1 Characteristics of cohort according to 15-year survival

Characteristic	Alive n=32	Dead n=102	OR (95% CI)	p Value
Age*	48 (44–54)	53 (47–58)	1.08 (1.02 to 1.13)	0.01
Male gender	18 (56.3)	78 (76.5)	2.53 (1.10 to 5.83)	0.03
Smoker	12 (50.0)	72 (72.7)	2.67 (1.07 to 6.65)	0.04
Subsequent abstinence	13 (41.9)	17 (16.8)	0.28 (0.12 to 0.687)	0.01
Ascites	2 (7.1)	20 (20.8)	3.42 (0.75 to 15.64)	0.11
HE	1 (3.6)	4 (4.3)	1.20 (0.13 to 11.20)	0.87
Prev features PHT	8 (26.7)	44 (44.0)	2.16 (0.88 to 5.32)	0.09
Albumin*	44 (42–47)	39 (32–44)	0.83 (0.75 to 0.92)	0.01
Child's Pugh	9 (9–10)	10 (9–12)	1.26 (1.19 to 2.59)	0.01

Conclusion In out-patients with biopsy-proven advanced ALD, clinical but not histological factors determine prognosis. Age, persistent alcohol intake, smoking habit and serum albumin are independent poor prognostic factors. Abstinence from alcohol and smoking cessation should be the priorities in the long-term management of ALD.

Competing interests None declared.

PWE-286 DIRECT SERUM MARKERS ARE MORE ACCURATE THAN SIMPLE MARKER PANELS FOR THE DETECTION OF FIBROSIS IN NON-ALCOHOLIC FATTY LIVER DISEASE (NAFLD)

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¹S Tanwar, ²P M Trembling, ¹D Thorburn, ²I N Guha, ³J Parkes, ²P Kaye, ⁴A Burt, ²S D Ryder, ²G Aithal, ⁴C Day, ¹W M Rosenberg. ¹Centre for Hepatology, University College London (UCL), London, UK; ²National Institute for Health Research: Biomedical Research Unit, Nottingham University Hospitals NHS Trust, Nottingham, UK; ³Public

Abstract PWE-286 Table 1

Test	F0 vs F1–4 AUROC (95% CI)	F0–1 vs F2–4 AUROC (95% CI)	F0–2 vs F3–4 AUROC (95% CI)	F0–3 vs F4 AUROC (95% CI)
Fib4	0.692 (0.614 to 0.771)	0.783 (0.715 to 0.851)	0.846 (0.755 to 0.937)	0.846 (0.754 to 0.938)
APRI	0.708 (0.631 to 0.784)	0.728 (0.652 to 0.803)	0.814 (0.707 to 0.921)	0.813 (0.706 to 0.921)
NAFLD FS	0.673 (0.594 to 0.753)	0.755 (0.684 to 0.826)	0.856 (0.782 to 0.931)	0.856 (0.781 to 0.930)
CDS	0.584 (0.501 to 0.668)	0.588 (0.501 to 0.675)	0.634 (0.491 to 0.778)	0.631 (0.487 to 0.775)
BARD	0.644 (0.560 to 0.728)	0.616 (0.532 to 0.700)	0.730 (0.602 to 0.858)	0.733 (0.606 to 0.860)
BAAT	0.600 (0.515 to 0.684)	0.660 (0.577 to 0.743)	0.522 (0.377 to 0.668)	0.517 (0.372 to 0.663)
HA	0.716 (0.641 to 0.791)	0.804 (0.739 to 0.868)	0.915 (0.862 to 0.968)	0.911 (0.856 to 0.965)
ELF	0.759 (0.689 to 0.828)	0.813 (0.747 to 0.879)	0.942 (0.902 to 0.981)	0.937 (0.896 to 0.979)

Health Sciences and Medical Statistics, University of Southampton, Southampton, UK; ⁴Institute of Cellular Medicine, Newcastle University, Newcastle, UK

Introduction The identification of fibrosis in patients with NAFLD is important for ascertaining prognosis and stratifying patients for emerging therapeutic interventions. Use of both direct marker panels (liver matrix components) and indirect marker panels (simple biochemical tests) have been described for the detection of fibrosis in NAFLD. The aim of this study was to compare the performance of direct and indirect serum marker panels in the detection of fibrosis in NAFLD as compared with liver biopsy.

Methods From two centres, 177 patients were recruited and underwent percutaneous liver biopsy. Fibrosis staging was assessed using Kleiner criteria by two senior liver-histopathologists. Serum at the time of biopsy was used to calculate six indirect marker panels of fibrosis (APRI, BAAT, BARD, Cirrhosis discriminate score, NAFLD fibrosis index and Fib4). These panels were compared with the ELF Test (HA, TIMP1, PIIINP) and HA alone. Diagnostic accuracy was assessed using receiver operating characteristic curves which were compared using the method of DeLong.

Results The distribution of fibrosis stages in the cohort were as follows: F0 39.5% (n=70), F1 19.2% (n=34), F2 17.5% (n=31), F3 13.6% (n=24), F4 10.2% (n=18). While ELF and HA alone had the best performance overall, the ELF test was better than HA in its ability to discriminate minimal fibrosis (p=0.02) and cirrhosis (p=0.06). All indirect serum markers tested had significantly worse performance than ELF in the detection of cirrhosis (p<0.05).

Conclusion In patients with NAFLD, direct serum marker panels have superior performance compared to indirect marker panels allowing superior stratification and prognostication. The performance of HA alone is enhanced by the addition of PIIINP and TIMP1.

Competing interests None declared.

PWE-287 BREATH VOLATILE ANALYSIS FOR THE RECOGNITION OF HARMFUL DRINKING, CIRRHOSIS AND HEPATIC ENCEPHALOPATHY

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¹T Y Khalid, ²B De Lacy Costello, ²R Ewen, ³P White, ²S Stevens, ⁴F Gordon, ⁴P Collins, ⁴A McCune, ⁵A Shenoy, ⁶S Shetty, ²N M Ratcliffe, ¹C S Probert. ¹Department of Gastroenterology, University of Liverpool, Liverpool, UK; ²Centre for Research in Biosciences, University of the West of England, Bristol, UK; ³Department of Mathematical Sciences, University of the West of England, Bristol, UK; ⁴University Hospitals Bristol NHS Trust, Bristol, UK; ⁵Colchester Hospital NHS Foundation Trust, Essex, UK; ⁶Dudley Group of Hospitals NHS Foundation Trust, Dudley, UK

Introduction Hepatic encephalopathy (HE) is a neuropsychiatric state which may complicate cirrhosis following the accumulation of toxic substances that cross the blood-brain barrier and affect brain function. Cirrhosis or portal-systemic shunting results in the accumulation of substances in the blood that may undergo alveolar gas exchange to be excreted in the breath. The aim of this work was to