(22%) and drug-induced hepatitis (12%). The commonest reason for admission was decompensated liver disease seen in 32% of patients. 14.5% of patients experienced variceal haemorrhage at or during admission. There was a significant difference in mortality, in-hospital complications and the need for tertiary centre referral between patients with and without cirrhosis. The commonest in-hospital complications were infection and renal dysfunction; 16% of our patients required ICU support. There was no significant difference in median length of stay (LOS) between patients with and without cirrhosis. However patients with cirrhosis had more complex discharge requirements as demonstrated by referral to social services.

Abstract PWE- Table 1 Demographics & Outcomes

	Cirrhosis (n = 46)	Non-Cirrhosis (n = 23)
Gender: Male:Female	30:16	15:8
Age range (mean)	37–84 (54)	23–74 (49)
Ethnicity: White:Non-White	25:21	9:14
Inpatient complications (%)	14 (20%)	0
Mortality (%)	5 (7%)	0
Tertiary centre transfer (%)	7 (10%)	0
LOS range (median)	1–46 (6)	1–36 (7)
Section 2 social work referral	11	4

Conclusion Patients with cirrhosis have significantly more complex in hospital stay and discharge needs compared to patients without cirrhosis. Our study has shown a significantly lower mortality for patients with liver disease than previous studies. We suggest that management by a hepatologist and access to tertiary services improves mortality. The complexity of patients with cirrhosis suggests that a multi-professional team is required to reduce overall LOS.

Disclosure of Interest None Declared.

REFERENCE

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PWE-135 HEPATITIS E: AN EMERGING INFECTION IN NORTH EAST OF SCOTLAND?

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Introduction Hepatitis E virus (HEV) is enterically transmitted and is endemic in some areas of the world. In the UK it was generally thought to be associated with travel but infection in those with no history of travel outside the UK has recently been recognised.[1] We reviewed data of patients with serologically proven acute HEV infection in North East of Scotland.

Methods The Regional Virology database was interrogated to identify all patients who had serological testing for acute HEV infection {anti-HEV IgM antibody [recomWell ELISA kits (Mikrogen)]} between March 2011 and November 2012. Casenote review was performed in those with positive serology. Presenting features and clinical course were recorded in addition to demographics, occupation, travel history, biochemical abnormalities, imaging and liver biopsy results.

Results There were 105 patients who had serological testing for evidence of acute HEV infection and 12 (11%) yielded positive IgM results, with HEV RNA detectable in 10/12 (83%) using an in-house real time RT-PCR assay.

Of the 12 confirmed cases, 10 (83%) were male and median age was 54.5 years. There was no history of travel outwith the UK in 7

(60%). Presentation was with flu like illness in 75% and clinically detectable jaundice was present in 66%. Hospitalisation was needed in 83%.

All patients had a significant transaminitis, median ALT 1487 IU/L (range 117–5645). The ALT to AST ratio was greater than 1. Serological screening for other causes of acute hepatitis was negative. IgA was elevated in 58% cases. Imaging was normal in 6 (50%), with fatty change in 3 (25%) and calculi confined to the gall bladder alone in 4 (33%) cases. Two patients underwent liver biopsy to exclude pre-existing liver disease. In both the features noted were consistent with viral liver injury.

All patients had spontaneous clinical and biochemical resolution with median time to normalisation of ALT of 6 (range 4–26) weeks. One patient developed both clinical and biochemical thyrotoxicosis which resolved spontaneously with resolution of HEV-associated clinical symptoms. Of interest, during the same study period 6 cases of acute Hepatitis B and 3 cases of acute Hepatitis A infection were diagnosed in our region.

Conclusion In our region, prevalence of HEV related acute hepatitis is higher than previously perceived and appears to be more common than acute Hepatitis A and B. Acquisition of HEV infection occurs in the UK often without travel history or obvious source of infection. Therefore, we suggest routine testing for HEV in patients with significant transaminitis.

Disclosure of Interest None Declared.

REFERENCE

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PWE-136 THE EFFECT OF C282Y HOMOZYGOSITY ON FULL BLOOD COUNT INDICES

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Introduction Full blood count (FBC) indices and iron studies are utilised in initial screening of patients with clinical suspicion of haemochromatosis and HFE genetic testing is used for diagnosis. The aim of this study is to determine what effect haemochromatosis has on FBC indices and to detect any correlation with iron overload in subjects with C282Y homozygosity.

Methods Data were obtained from blood samples taken from first time donors to the Australian Red Cross Service prior to venesection. FBC indices were recorded from C282Y homozygous patients and also from an age-matched healthy control group. Ferritin levels from the haemochromatosis group were also obtained. All P values were derived from two-tailed statistical tests and Chi-square tests. P values of less than 0.05 considered significant. Multivariate regression analysis was used to assess the differences between blood donors and haemochromatosis patients.

Results The HFE group and normal controls were well matched with forty males and forty females in each group and no significant difference in age between the groups. Males homozygous for C282Y had a significantly (P = 0.001) higher mean ferritin level 787.3 mcg/L (522.1–1052.6) compared with females 268.3 mcg/L (147.1–389.4). Eighty percent of C282Y homozygous males presented with iron overload on their first Red Cross Blood donation visit, whereas only fifty percent of C282Y homozygous females had an elevated ferritin level on their first visit (P = 0.045). Of the forty patients homozygous for the C282Y mutations, there was evidence of iron overload in 26 patients (as defined by a ferritin greater than 200 mcg/L). There was no significant difference in all measure parameters between haemochromatosis patients with a

ferritin lower than 200 mcg/L and healthy blood donors. Haemochromatosis patients with a ferritin level above 200 mcg/L ($n = 26$) had significant increases in haemoglobin (Hb) ($P < 0.001$), mean cell volume (MCV) ($P < 0.026$), mean corpuscular haemoglobin (MCH) ($P < 0.001$) and mean corpuscular haemoglobin concentration (MCHC) ($P < 0.002$).

Conclusion Patients with C282Y homozygous haemochromatosis had a significantly higher Hb, MCV, MCH and MCHC. There is a clear correlation between ferritin and these raised red cell indices. A ferritin greater than 200 mcg/L is associated with a significant increase these red cell indices. Further studies are required to determine whether this increase in red cell indices is reversible with therapeutic venesection.

Disclosure of Interest None Declared.

PWE-137 FOUR PATIENTS WITH AMANITA PHALLOIDES POISONING

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Introduction Mushroom poisoning is a rare problem. We report four concomitant cases of amatoxin intoxication, the most deadly cause of mushroom poisoning.

Methods Case

Four women, living together in a convent, were admitted because of nausea, vomiting and diarrhoea. Symptoms started approximately 10 hours after eating wild mushrooms, self-picked in the forest. Laboratory data, 24 hours after ingestion, showed normal liver enzymes in 2 patients and normal INR and bilirubin in all 4 patients. Because of suspected amatoxin intoxication, a therapy with intravenous fluid, N-acetylcysteine and silibinin was started. 36 hours after intoxication, complaints of vomiting and diarrhoea improved in all 4 patients. Blood analysis however showed a dramatic increase of the liver enzymes in 3 of 4 patients (ALT-range 48 hours after ingestion: 558–1762 U/L), and an elevation of bilirubin and INR in all 4 patients. Two patients were transferred to a transplantcentre 48 hours after mushroom poisoning because they developed stage 2 hepatic encephalopathy. With maximal supportive therapy, all patients gradually improved from day 3 on. They were discharged from the hospital between 6 to 10 days after admission.

Results Discussion

Our patients showed the typical clinical syndrome of an amatoxin intoxication. This syndrome can be divided into 3 phases. The gastrointestinal phase (starts 6–40 hours after consumption) is characterised by vomiting and diarrhoea and lasts 12–24 hours. In amatoxin intoxication, symptoms develop typically more than 6 hours after ingestion, while other toxic mushrooms cause symptoms earlier, after 0.5–3 hours. Blood analysis at this initial stage shows normal liver and kidney function. A careful history is very important, to avoid the risk that patients are discharged too early with a diagnosis of a common gastroenteritis. The second phase is characterised by an apparent recovery 36–48 hours after ingestion, while biochemistry shows a progressive increase of transaminases. In the third phase (2–6 days after ingestion), patients can develop hepatic failure, often complicated by renal failure. The therapy of amatoxin intoxication consists of supportive care and medical therapy with silibinin and N-acetylcysteine. Therapy with activated charcoal can be beneficial, if started early after the intoxication. We did not treat our patients with activated charcoal because of vomiting and presentation of the patients 24 hours after ingestion. Patients who develop liver failure should be transferred to a transplantcentre.

Conclusion Amatoxin intoxication is a rare cause of liver failure. When suspected, careful monitoring of the liver function and treatment with silibinin and N-acetylcysteine are mandatory.

Disclosure of Interest None Declared.

PWE-138 TREATMENT OF PATIENTS WITH CHRONIC HEPATITIS C GENOTYPE 1 AND ADVANCED FIBROSIS WITH PROTEASE INHIBITORS- IL28B DISCORDANCE RESULTS IN EARLY VIRAL DECLINE BUT LATE RELAPSE

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Introduction We report the impact of host and viral factors on treatment outcome in the first 53 patients who have completed therapy for CHC with either telaprevir or boceprevir, in combination with pegylated-interferon and ribavirin (PEG/R) at our centre.

Methods Patients were treatment naïve or experienced with F3 or F4 fibrosis, CHC genotype1 and HCV RNA > 10,000 IU/ml. Data were collected on host and viral factors including single nucleotide polymorphisms (SNPs) in the IL28B gene noncoding region at sites rs12979860 and rs8099917.

Results 53 patients (42 Caucasian, 32 F4) were treated with TVR ($n = 41$) and BOC ($n = 12$). Seven patients were treatment naïve. Subtyping was unattainable in 2 patients. Thus far, 18 patients (34%) have failed treatment and the remainder are being evaluated for SVR (24 patients with SVR-4 to date).

HCV viral negativity at triple therapy week 4 was associated with treatment success in patients with rs12979860CC and rs8099917TT and rs12979860non-CC and rs8099917non-TT (OR 20.2 P -value < 0.001) but not in patients with discordance between the two IL28B polymorphisms (rs12979860non-CC and rs8099917TT, P -value = NS). Despite 86% HCV RNA negativity at triple therapy week 4, patients with discordant IL28B genotype results demonstrated a failure rate of 43% predominantly due to virologic breakthrough during PEG/R. In addition, all patients who ultimately failed therapy after attaining eRVR and qualifying for shortened therapy had IL28B genotype discordance. Multivariate logistic regression identified that HCV negativity at triple therapy week 4 (p -value < 0.001), rs12979860 (p -value = 0.02) and rs8099917 (p -value = 0.001) were all independent predictors of treatment outcome after accounting for the remaining factors as potential confounders.

Abstract PWE-138 Table

	Undetectable HCV-RNA, triple therapy wk-4	EOT HCV-RNA negative
rs12979860 CC, rs8099917TT ($n = 10$)	90%	100%
rs12979860 non-CC, rs8099917TT ($n = 14$)	85%	57%
rs12979860 non-CC, rs8099917non-TT ($n = 29$)	69%	66%

Conclusion In our prospective cohort of CHC patients with advanced fibrosis treated with PIs, HCV RNA negativity at triple therapy week 4 and both IL28B genotypes were independent predictors of treatment outcome. Despite similar rates of early viral suppression, our preliminary data indicate more favourable end of treatment results for rs12979860CC and rs8099917TT versus rs12979860non-CC and rs8099917TT.

Disclosure of Interest None Declared.