New Castle Variceal Risk in PBC Score Calculator

* The Newcastle Risk Score:

$$1 / 1 + \exp \{ -9.186 + (0.001 * \text{alkaline phosphatase in IU}) - (0.178 * (\text{albumin in g/L})) - (0.015 * \text{platelets} \times 10^9) \}$$

After entering serum albumin in g/L, platelet count (10^9) and alkaline phosphatase in IU click the Calculate button. Your Risk Score will then be computed and displayed in the "Predicted risk of Varices =" text box

Input:

Enter Your Serum Albumin: (g/dL)
 Enter Your Platelets: ($\times 10^9$)
 Enter Your Alkaline Phosphatase: (IU)
 Your reference Alkaline phosphatase range*: to (IU)
 Calculate =

Output:

Predicted risk of Varices = %

Abstract PWE-146 Figure 1

with primary biliary cirrhosis based on serum albumin levels, platelet count and serum alkaline phosphatase level. A easy accessible online tool is available where values can be entered and score greater than 50% is considered to predict the presence of varices, thereby warranting oesophago-gastro-duodenoscopy (OGD). The aim of this study was to validate this score in an external validation cohort from Liverpool.

Methods Retrospective study involving 80 PBC patients under follow up at a university hospital. Of them, patients who had undergone a OGD for any clinical reason were identified and findings of the OGD noted. Results of blood tests to allow calculation of the NVP score were recorded. An NVP probability of 0.5 was used as the cut-off to analyse the performance of the score.

Results Patients involved in the study had mean albumin levels of 36, platelets of 260 with an ALP ranging between 58 and 811. 97% were female and median age of patients was 67 years. 30 PBC patients who had an OGD were identified. 10 of the 30 patients had varices on endoscopy. The NVP Score performed well in identifying those in whom varices were absent in this cohort (sensitivity of 100%, specificity 69%, Negative Predictive Value 100% and Positive Predictive Value 10%; overall accuracy 84.5%) and had a good discriminating power with AUROC 0.89.

Conclusion The NVP Score proved to be a highly sensitive tool to discriminate patients with PBC who do not have varices and in whom OGD is unnecessary in our cohort. The study therefore strongly supports the view that prospectively applying the score in patients with PBC will help to direct endoscopic evaluation in the right category of patients thereby ensuring effective use of resources.

REFERENCE

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Disclosure of Interest None Declared.

PWE-147 NURSE LED DAY CASE PARACENTESIS

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Introduction Refractory ascites is a debilitating condition. Prior to the implementation of nurse led day case paracentesis all patients were admitted into the hospital for an inpatient stay of

between 3 and 5 days. An audit of inpatient paracentesis was carried out to assess the quality and efficiency of inpatient paracentesis. From this the service was developed to improve the overall quality of the patient experience and reduce inpatient admissions for paracentesis. Disease aetiology includes alcoholic liver disease, viral disease, autoimmune disease and advanced malignancy.

Methods The hepatologist CNS was trained by the consultant hepatologist to perform paracentesis. All patients requiring paracentesis are referred directly to the CNS from GP's, out patient clinics and the accident and emergency department. Patients are assessed in a pre procedure clinic by the CNS. A clinical examination is performed, bloods are checked and if necessary corrected accordingly to facilitate day case paracentesis. To date, the CNS has performed over 200 day case paracentesis procedures and complication rates remain below the national average.

Results Data collected from a patient feedback exercise was extremely positive in all aspects of the nurse led day case paracentesis service. An audit of the service demonstrated no difference in overall outcomes when the CNS performed the paracentesis in comparison to the medical registrar. There has been a significant reduction in hospital bed days required for paracentesis.

Conclusion Nurse led day case paracentesis is a safe, effective and economic alternative to costly inpatient hospital admissions. It has proven to be both beneficial to the service user and the NHS trust. Patients benefit from a key worker who specialises in the management of refractory ascites who can provide management and out patient intervention to avoid the potential complications of large volume refractory ascites and unnecessary hospital admissions.

Disclosure of Interest None Declared.

PWE-148 LONG TERM OUTCOMES OF PERCUTANEOUS RECANALISATION FOR BUDD-CHIARI SYNDROME (BCS): OUR EXPERIENCE IN BIRMINGHAM, UK

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Introduction Patients with BCS and short stenosis of the hepatic vein or the upper IVC can be treated with recanalisation by percutaneous venoplasty $\pm$ hepatic vein stent insertion. Recent data suggests >60% failure rate (PMID 23389867). We studied the long-term outcomes of this approach in our institution.

Methods Retrospective analysis of patients referred from 1987 to 12/2012 for radiological intervention. Of 161 patients treated for BCS, 60 patients were selected.

Results Median age, 34.5 years (19–65), M:F ratio 23:37. Mean follow up, 8 ± 6.6 years (0.1–26 years). 60% of patients had ≥ 1 haematological risk factor. Percutaneous recanalisation was technically successful in all patients. The obstruction was at the level of hepatic vein (s) (86.6%), IVC (6.6%) and both IVC and HV (6.6%). 30 patients were managed with venoplasty alone. Of the 30 who had stent placement, 15 had venoplasty prior to stent placements, ranging from 1–11 venoplasty episodes. Due to failure of recanalisation, 26.66% patients required TIPSS (16.7%), surgery (8.3%) and liver transplantation (6.7%). Actuarial survival at 1, 5, 10 was 95%, 93%, and 83% respectively (*kaplan meier survival Graph 1*). All patients maintained Child's