PMO-147

RECOMBINANT ERYTHROPOETIN SUPPORT IS EQUALLY EFFECTIVE IN THE TREATMENT OF HCV PRE AND POST TRANSPLANT

doi:10.1136/gutjnl-2012-302514b.147

A Barnabas,* D Joshi, K Agarwal. Institute for Liver Studies, Kings College Hospital, London, UK

Introduction Recombinant EPO is often used in an attempt to improve Hepatitis C virus (HCV) treatment outcomes in complex patient groups. We assessed if its use was as effective in the post-transplant population as in a non-transplant group that also required EPO support. There is currently an absence of clear guidelines in this area and little evidence to support its efficacy overall.

Methods Between December 2009 and July 2010, 57 patients were prescribed EPO while undergoing HCV treatment. In this group, 15 patients who had undergone liver transplantation were identified. These were matched by HCV, genotype, gender and stage of liver fibrosis with a non-transplant group also treated with EPO. Numbers of patients being re-treated for HCV were similar in transplant and non-transplant groups (6/15 and 7/15 respectively).

Results 3/15 (20%) in the transplant group and 1/13 (7.7%) patients in the transplanted group achieved a sustained virological response to treatment. Discontinuation rates, however, were lower in the non-transplant group (4 vs 8, OR 10.4). The initial Hb was not significantly different between the two groups (mean 12.7g/dl in the transplant group and 13.4g/dl in the non-transplant group, p=0.39). Mean decrement in Hb was similar in transplant and non-transplant groups over the first 8 weeks of treatment (3.07 vs 2.54 g/dl) and the mean time to nadir in haemoglobin was similar in both groups (16 vs 19 weeks). 7/15 (47%) (non-transplant vs 7/13 (54%) transplant patients had a Hb decrement >4 mg/dl on treatment (OR 0.63). Five patients (38%) in the transplant group and 7 (47%) in the non-transplant group required EPO prior to treatment week 8. Median treatment duration was shorter in the transplant group (24 vs 48 weeks). Ribavirin dosages varied widely in both groups (16 vs 19 weeks). 7/15 (47%) (non-transplant vs 7/13 (54%) transplant patients had a Hb decrement >4 mg/dl on treatment (OR 0.63). Five patients (38%) in the transplant group and 7 (47%) in the non-transplant group required EPO prior to treatment week 8. Median treatment duration was shorter in the transplant group (24 vs 48 weeks). Ribavirin dosages varied widely in both groups and there was significant variation in ribavirin dose reduction strategies. One patient in the non-transplant group developed a deep vein thrombosis and one patient in the transplant group had a CVA while on treatment with EPO.

Conclusion Anaemia related to hepatitis C treatment both presents and is managed similarly in both transplant and non-transplant difficult-to-treat populations. The risk of thrombotic events with EPO use is significant should be carefully borne in mind when initiating EPO support.

Competing interests None declared.

PMO-149

TENOFIVIR USE IN HEPATITIS B INFECTION IN PREGNANCY

doi:10.1136/gutjnl-2012-302514b.149

G Chakrabarty,* S Clark, D Forton. Department of Hepatology, St Georges University of London, London, UK

Introduction Antenatal screening and immunoprophylaxis reduces the perinatal transmission of hepatitis B virus but vertical infection may occur with high level viraemia. Antiviral therapy during the 3rd trimester of pregnancy may reduce the incidence of intruterine infection. Lamivudine treatment reduces vertical transmission if given with immunoglobulin and vaccination in mothers with viral loads >10^5 IU/ml. There are no published trials for tenofovir in this context, although its use is supported by safety data from Anti-retroviral Pregnancy Registry in USA (category B) with the added benefit of low viral resistance. Breastfeeding is not recommended as tenofovir is secreted in milk. Discontinuation of tenofovir after delivery carries the risk of hepatitis flares and liver decompensation. There are no guidelines for the use of antivirals in HBV+ve pregnant women and treatment decisions are made on an individual basis.

Methods We initiated tenofovir 245 mg in five HBV monoinfected women in the 3rd trimester to prevent vertical transmission. Demographic, virological and outcome data were collected.

Results The patients were newly diagnosed during antenatal screening. The patients had HBeAg+ve with high viral loads and normal ALT, presumed immunotolerant. All women wished to breastfeed and four were advised to stop tenofovir at delivery but