Introduction  The global incidence of HCC is rising and it is the third most common cause of cancer-related death worldwide. Surveillance of at-risk patients has been recommended by expert guidelines to detect early cancers that are amenable to curative treatments. AASLD has recommended HCC surveillance for non-cirrhotic HBV-positive Asian males over 40 and females over 50yrs of age. However, the evidence to support this recommendation is limited and is derived from studies conducted in Asia. Results from such studies may not be applicable in the West, due to differences in environmental risk factors and availability of HBV treatment. Implementation of such a recommendation would place a burden on healthcare resources, and may not be justifiable if the risk for HCC is substantially lower than previous estimates in this population.

Methods  A retrospective study was carried out of all Asian patients undergoing follow up for HBV infection from 1990 to 2012. Patients were classified as cirrhotic or non-cirrhotic according to clinical, biochemical, radiological and histological results. Follow-up was until September 2012, and was censored at time of death, development of cirrhosis or loss to follow-up.

Results  Among 316 identified Asian patients with HBV, 73 non-cirrhotic patients fulfilled the proposed AASLD surveillance criteria, either at time of initial referral or during the period of follow-up. The median at-risk follow up period (as defined by AASLD guidelines for non-cirrhotic Asians) was 57 months (range: 0–354 months). HCC was diagnosed in one non-cirrhotic patient after 77 months of follow up (male, 60yrs), two patients became cirrhotic after 49 and 89 months (male, age 46 and 55yrs) and no deaths occurred. The overall incidence of HCC in the non-cirrhotic cohort meeting the AASLD surveillance criteria was 1 per 429.5 patient-years of follow-up (0.23% per patient-year).

Conclusion  The incidence of HCC in Asian patients with non-cirrhotic HBV is low in our cohort. This low incidence challenges the rationale for surveillance in this group of patients. More studies are needed to assess the benefit of such approach.

Disclosure of Interest  None Declared.

PWE-114  FACTORS AFFECTING THE RISK OF RELAPSE TO DRINKING ALCOHOL FOLLOWING LISTING FOR TRANSPLANTATION FOR ALCOHOL-RELATED LIVER DISEASE

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Introduction  Alcohol-related liver disease (ALD) is one of the commonest indications for liver transplantation, but relapse to drinking alcohol in this group of patients is a significant concern. Clarification of risk factors that can predict relapse is needed in the UK, so that additional support can be provided for those at increased risk.

Methods  Patients being considered for liver transplantation as a result of ALD in Leeds undergo thorough assessment by an alcohol professional. Particular emphasis is placed on the risk of recidivism to drinking, using 2 scoring systems. One of these, the High-risk Alcohol Relapse (HRAR) Score, focuses on prior alcohol consumption history, whereas the Relative Risk Factors for Relapse (RRFR) Score addresses psychosocial dysfunction. However, neither of these scoring systems is used to determine suitability for transplantation.

Scores were evaluated in those known to have returned to drinking alcohol after listing for transplantation, either by self-report or by random blood alcohol testing. These scores were compared to listed patients considered to be abstinent. We also assessed whether duration of self-reported abstinence or family history of alcoholism were greater in those who relapsed.

Results  Between September 2008 and August 2010, 58 people with ALD were listed for liver transplantation. Of these, 12 are known to have returned to drinking alcohol, either whilst listed or post-transplant.

There was no significant difference in the relapsers compared to the non-relapsers according to gender (0.67% vs 0.73% were males, P = 0.45) or age (median 50 vs 54 years, P = 0.09).

The median RRFR scores were significantly higher in the relapsers compared to the non-relapsers (14.5/27 vs 12/27, P = 0.01). The median HRAR scores were identical in the 2 groups (median scores 2/6, P = 0.28).

There was no significant difference in duration of self-reported abstinence between relapsers and non-relapsers (15 vs 10 months; P = 0.26). There was also no difference in family history (where known) of alcoholism between the 2 groups (1/10 vs 8/39; P = 0.4).

Conclusion  Psychosocial dysfunction is significantly greater in patients with ALD who relapse to drinking alcohol following listing for transplantation. Psychological support may therefore reduce the risk of relapse in these patients. The predictive utility of the HRAR score was poor in this cohort of patients.

Disclosure of Interest  None Declared.
serial measurement of aFP in patients with liver cirrhosis in contrast to European and American guidelines.

Disclosure of Interest None Declared.

REFERENCES

Introduction
Chronic hepatitis C virus infection (HCV) is a common cause of cirrhosis and end-stage liver disease. Pegylated interferon (PEG-IFN) and ribavirin (RBV) is currently the treatment of choice for genotype 3 (G3) HCV resulting in a sustained virological response (SVR) in 70–80%. Advanced fibrosis is known to be associated with failure of antiviral therapy. Increasingly, liver stiffness measurement (LSM) is being used to non-invasively assess fibrosis. However, it is not known whether LSM predicts response to antiviral therapy and whether there are predictive cut-offs. Our aim was to assess whether baseline LSM can predict SVR in HCV G3 patients treated with PEG-IFN+RBV.

Methods
Retrospective review of outcomes in naive patients with HCV G3 treated with PEG-IFN+RBV in our clinic from Jan 2007 to Oct 2011. Post transplant and co-infected patients were excluded. Patients with a valid LSM within 1 year of starting treatment who completed >12wks and recorded outcome of treatment were included in the LSM analysis.

Results
144 patients (mean age 40±10 years, 56% male, 16% cirrhotic, and 42% high viral load) received PEG-IFN+RBV for HCV in the study period. 92% completed >12wks treatment. 92 (64%) of patient's had valid LSM. (median 6.5kPa, 3.5kPa to 39.1kPa). 24% had a LSM >10.6kPa consistent with advanced fibrosis. The overall SVR rate was 68%. 11% were lost to follow up and the outcome unknown. LSM was significantly associated with SVR (p = 0.001). The AUROC for LSM in predicting treatment response was 0.74 (95% CI 0.55–0.90). The optimum cut-off to predict non-SVR was 10.6kPa (69% sensitivity, 85% specificity). 90% with LSM ≤10.6kPa achieved SVR versus 47% with LSM > 10.6kPa (p < 0.001). All patients with low viral load (<600,000 IU/mL) and LSM ≤10.6kPa who had >12wks treatment achieved SVR (n = 35).

Conclusion
Fibrosis assessed non-invasively with LSM can help predict response to antiviral therapy in patients with HCV G3. LSM (> or < 10.6kPa) could be factored into treatment algorithms to determine the optimum treatment course lengths.

Disclosure of Interest None Declared.