Introduction Upper gastrointestinal haemorrhage (UGIH) is a common medical emergency worldwide. The Glasgow Blatchford (GBS) and pre-endoscopy Rockall (PERS) scores are used to predict outcome and need for intervention. This retrospective study aims to determine their value in a mixed rural and urban population in New Zealand.

Methods GBS and PERS were determined for all adult patients admitted with UGIH to our teaching hospital between January 2007 and November 2011. Need for therapy (endoscopic, blood transfusion or surgery), 30-day mortality and 14-day re-bleed rate were recorded and the optimum scoring system for predicting low risk patients determined by logistic regression. The Lower South Regional Ethics Committee approved the study.

Results There were 424 admissions with UGIH: data was complete for 388 admissions to enable PERS and GBS calculation. Median age was 74.3 years, 55.1% were male and the majority were New Zealand European (85.8%). Commonest findings were oesophageal, gastriatis, duodenitis (45%), peptic ulcer (35.5%), hiatus hernia (16.8%), normal (11.9%), varices (4.8%) and malignancy (5.1%). 181 cases (46.6%) received an intervention, of which 75 (19.3%) had an endoscopic intervention, 147 (37.9%) a blood transfusion, 8 (2.1%) surgery and 7 (1.8%) an iron infusion. 30-day mortality was 4.6% (18 patients) and 14-day re-bleed rate was 6.0% (23 patients). GBS < 1 predicted low risk (no intervention, re-bleed or mortality), accounting for only 3.1% of all admissions (14 patients). 42 (10.8%) had a PERS of 0 but intervention was required in 15 (35.7%). A further 193 patients had outpatient gastroscopy for UGIH and 113 had inpatient bleeds during the study period.

Conclusion GBS (of < 1) is superior to PERS in identifying low risk patients who could be safely managed as outpatients following UGIH saving health resources. Despite having less patients with varices we had fewer low risk patients than British studies. Low risk patients may have been triaged to outpatient endoscopy by Primary Care.

Disclosure of Interest None Declared.
thoroughly as infection with Hepatitis C Virus (HCV). The aim of this audit was to assess the number of service users chronically infected with HBV and their relevant co-infections, co-morbidities and access to treatment.

Methods The Tower Hamlets Specialist Addiction Unit serves the London Borough of Tower Hamlets with a population of more than 200,000. Its Blood Borne Virus Team (BBVT) provides harm reduction healthcare in more than 10 drug and alcohol addiction facilities including outreach sites and neighbouring boroughs. Data on service users chronically infected with HBV was extracted from the service database.

Results Of 2577 people currently registered with the BBVT 49 (1.9%) have chronic HBV infection with detectable HBs-Antigen. 88% are male, the average age is 40 years and the majority is of non-British origin with large groups of Baltic (18%) and Black/African/Caribbean (20%) ethnicity. 16 patients (53%) are currently injecting drug users (IDU), 13 (27%) formerly IDU. Other reasons for referral are non-injecting drug and alcohol use. 14/49 patients (29%) have psychiatric comorbidities other than drug/alcohol abuse. 22 patients (45%) knew about their infection when they entered the service.

12 patients (24%) have HBe-Antigen-positive and 37 (76%) HBe-Antigen-negative disease. 12/49 patients (24%) have detectable HCV-RNA and can be regarded as co-infected. 3/49 patients (6%) have detectable Hepatitis D Virus (HDV)-RNA. Two patients (4%) are infected with HBV, HCV and HDV. Two patients (4%) have active syphils co-infection and HIV-co-infection, respectively.

10/49 patients (20%) have been diagnosed with cirrhosis. One patient has undergone resection for HBV-associated hepatocellular carcinoma and has been followed up for 9 years without recurrence. Two patients were infected after documented vaccination against HBV. 7/49 patients (14%) are currently undergoing treatment with a regimen that is effective against HBV. Three patients have cleared HBV, one through treatment and two spontaneously.

Conclusion Even in a difficult setting where care can be interrupted by incarceration or psychiatric deterioration, successful health care for patients with chronic HBV infection is possible by using outreach facilities and appointment reminders. The community attending drug addiction services has overlapping risk factors and in East London, only a minority of patients chronically infected with HBV are currently injecting drug users. Vaccination against HBV has no 100% protection rate and service users should repeatly undergo testing for blood borne viruses.

Disclosure of Interest None Declared.