**PTU-092** THE MANAGEMENT OF ALCOHOL WITHDRAWAL IN PATIENTS WITH ADVANCED LIVER DISEASE

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**Introduction** Alcohol withdrawal syndrome (AWS) is a common reason for hospital admission. However a significant number of these patients have co-existent liver disease or other medical problems. There is little information regarding the management of these patients.

**Methods** Patients were assessed for hazardous drinking using the FAST score. Data was collected prospectively on FAST positive patients with regards to their subsequent treatment using a unified AWS guideline. Patients with known liver disease or presenting with decompensated liver disease were identified (Group 1) and compared with patients admitted with non-hepatic primary alcohol-related diagnoses (Group 2) and patients with admitted primarily non-alcohol related medical diagnoses (Group 3). Results are expressed as median (95% confidence).

**Results** 53 patients had significant liver disease (Group 1), with 153 in Group 2 and 106 in Group 3. Median MELD score in Group 1 was 15.4 [12.8, 17.6]. The three groups had similar FAST scores: 14 [12, 15], 14 [13, 14] and 13 [12, 14] respectively. Fewer patients in Group 1 and Group 3 required benzodiazepine (BZD) treatment compared with Group 2. When required, the median BZD prescription (mg diazepam equivalent) during admission was greater for Group 1 and Group 3 compared with Group 2. More patients in Group 1 were treated with lorazepam rather than diazepam; 13% in Group 2 (p = 0.04; 0.7, 22.3) compared with Group 2 (84%; p = 0.0005). 15/8% those diagnosed in surveillance underwent transplantation or resection, compared with 2.3% who were not (p = 0.004). Survival for those diagnosed in surveillance was greater than those diagnosed de novo (p = 0.01).

**Conclusion** Most patients diagnosed with HCC in our region were not in surveillance programmes. Patients diagnosed on surveillance were more likely to have potentially curative disease and had higher overall survival.

**Disclosure of Interest** None Declared

**REFERENCES**


APASL consensus on HCC. Hepatol Intern 2010; 4:439–74

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**Abstract PTU-092 Table**

<table>
<thead>
<tr>
<th>Group</th>
<th>Not Requiring BZD</th>
<th>Median BZD use (mg diazepam equiv)</th>
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</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>14 (26%)*</td>
<td>70 (48, 111)$</td>
</tr>
<tr>
<td>Group 2</td>
<td>16 (10%)#</td>
<td>130 (105, 160$–)</td>
</tr>
<tr>
<td>Group 3</td>
<td>35 (33%)#</td>
<td>40 (30, 80$–)</td>
</tr>
</tbody>
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*p = 0.008 (3.5, 30.5); # p < 0.0001 (12.4, 33.7); $p = 0.003; –p = 0.0001

There were correlations between the FAST score and subsequent amount of diazepam prescribed for Group 2 (p = 0.002; 0.09, 0.4) and Group 5 (p = 0.03; 0.02, 0.41), but not for Group 1 (p = 0.26; –0.12, 0.45). Overall survival until 33 months was less in Group 1 (64%) compared with Group 2 (84%; p = 0.0007 HR 0.29 [0.14, 0.60]) and Group 3 (81%; p = 0.016 HR 2.30 [1.17, 4.55]).

**Disclosure of Interest** None Declared

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**PTU-094** SHOULD LIVER BIOPSIES BE REPORTED BY PATHOLOGISTS WITH A SUBSPECIALIST INTEREST IN HEPATOPATHOLOGY?

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**Introduction** Histopathologists working in a district general hospital usually do not have a subspecialist interest in hepatology. Most district general hospitals have a gastroenterology service and local pathologists usually report liver biopsies. The Royal College of Pathologist (RCP) recommend that ‘as minimal acceptable practise’ a liver biopsy report should include the clinical diagnosis, biopsy size, overall architecture, degree of fibrosis, severity in chronic liver disease (staging/grading), a definitive diagnosis or discussion of the differential diagnosis. Appropriate negative findings (e.g. lack of iron overload or alpha-1-antitrypsin globules) should be documented in the report.

**Methods** A retrospective analysis of all liver biopsies between January 2010 to February 2012 at two district general hospitals (Barnet and Chasefarm NHS trust) in North London was performed. Data was collected from medical records and electronic results. Our aim was to assess whether liver biopsies provided the clinician with adequate information about diagnosis.

**Results** 107 liver biopsies were performed during this period under ultrasound guidance by a radiologist. Mean patient age was 62 years (Range 19 –90). The mean number of core biopsies per patient was 1.5 (range 1 – 6). 10.7% (10/107) of the report did not mention a clinical diagnosis. 50% (52/107) of the biopsy report did not have a...
definitive or a differential diagnosis about possible aetiology of underlying liver disease. However 98% (47/48) of patients with cancer had a diagnosis on histology. Only 53% (9/17) patients with chronic hepatitis had severity scoring (Ishak staging/grading).

Conclusion About one third of liver biopsies did not have diagnosis or discussion about a differential diagnosis. This number goes up to 47.5% (28/59) if we exclude malignancies. 9/28 specimens were sent to a tertiary centre and reported by a liver pathologist who gave a definite or differential diagnosis in all cases. The mortality associated with percutaneous liver biopsy ranges between 0.13 and 0.33%, from an audit from UK district general hospital. With the advent of fibroscan there is less need to perform liver biopsies except in diagnosing malignancies or in hepatitis of unknown/unclear aetiology. From our study we conclude that non-cancer liver biopsies should be reported by pathologists with subspecialist interest in hepatology or the procedure should be performed in a tertiary hospital to give the clinician an accurate diagnosis to aid treatment.

Disclosure of Interest None Declared