the ascitic fluid samples sent to our microbiology department. Case notes for these patients were reviewed and data were collected on patient demographics, aetiology of cirrhosis, use of blood products and human albumin solution (HAS) and volume of ascites drained.

**Results** 86 LVP were performed on 28 patients. 24 were male, age range 30 – 84 years (median 59 years). Alcohol was either the only or a contributory cause of cirrhosis in 25 (89%) of patients. None had hepatitis B or C virus infection.

5 patients received fresh frozen plasma (14 units in total) and 1 received octaplex® prior to LVP. The total cost was £1024.

8 patients had less than 5L ascites drained and received a total of 19 units of 20% HAS. 16 patients received more than 8g albumin per litre of ascites drained (a total of 31 unnecessary units). The total cost of this was £1400.

The potential cost saving per procedure was £49.47. However data on albumin administration was unavailable for 7 patients and this could be an underestimate.

**Conclusion** Alcohol is the predominant cause of cirrhosis requiring LVP in our population and working age men constitute the largest proportion. Significant cost savings can be made by avoiding unnecessary blood products and by avoiding excessive use of albumin or administering other fluids when less than 5 litres of ascites drained.

**Disclosure of Interest** None Declared

**REFERENCE**


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**PTU-104 SINGLE CENTRE MANAGEMENT OF PYOGENIC LIVER ABSCESSES: SURPRISINGLY POOR BUT MORTALITY STILL LOW**

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**Introduction** Untreated, pyogenic liver abscesses have a mortality approaching 100%. Three admissions in a week sparked interest in the best management of this condition. Although common, no comprehensive management guidelines could be found, prompting further review into how well this condition was managed locally.

**Methods** Retrospective analysis of all patients admitted to Watford Hospital between 2006 and 2011 with a diagnosis of pyogenic liver abscess. Data was collected to evaluate use of cultures, radiological intervention (aspiration or drain insertion), source of infection, investigation for cause, follow up and outcome.

**Results** Forty four admissions were identified: 39 patients with 5 re-admissions. Mean age was 62 yrs, 59% male, 41% female. Eleven patients were managed by the Gastro team.

Assumption of source was made on CT imaging results: 46% presumed portal translocation (most diverticular disease), 36% biliary, 18% unidentified. Blood cultures were taken in 24 patients (42% positive). Abscess aspirates were taken in 33 cases, sent for culture in 30 (50% positive). Presumed biliary or unidentified sources grew gramme negative organisms in 12/13 cases. Presumed portal sources grew gramme positives in 7/8 and anaerobes 1/8.

Abscess size was < 3 cm in 5 cases (incl. 2 readmissions). Four received antibiotics (Abc) alone:resolution in 3/4, 1/4 no follow up. One was managed to resolution with Abc and aspiration. Mean length of stay was 11 days.

In 6 patients the abscess was 3-5 cm. In this group, 1 patient with malignancy died, 1 treated successfully with Abc alone. The remaining 4 were treated with Abc and aspiration: 1/4 resolution, 1/4 readmitted, 2/4 no follow up. Mean length of stay was 15 days.

Thirty three patients had abscesses > 5 cm (incl. 8 readmissions). Nineteen were treated with Abc and drainage. 2/19 had underlying malignancy and died, 6/19 resolution, 5/19 readmitted. 9/19 no follow up, 1/19 referred to surgery. Of the remaining fourteen, 3/14 had Abc alone (2 resolved, 1 patient with two readmissions no follow up), 1/14 a readmission referred for surgery and 10/14 Abc and aspiration. Outcome in these ten: 1/10 multiple aspiration, 2/10 drain insertion, 1/10 surgical referral, 1/10 readmitted, 1/10 partial response, 3/10 no follow up, 1/10 resolution. Mean length of stay in > 5 cm group: 27 days.
Overall in all patients: investigation for cause limited to 3 colonoscopies and 1 ERCP, follow up inadequate in 15 (38%), mortality 8%. Conclusion Management of this serious condition was remarkably poor, with limited use of cultures, inconsistent radiologic intervention, no search for cause, and scanty follow up. Despite this confirmed mortality was just 8%. Guidelines for future management have been drawn up including recommendation that all patients are looked after by the Gastro team.

Disclosure of Interest None Declared

PTU-106 OUTCOME OF CIRROTIC PATIENTS ADMITTED TO INTENSIVE CARE UNITS AT HOSPITALS WITHOUT SPECIALIST LIVER SERVICES
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Introduction Patients with liver cirrhosis admitted to an ICU are believed to have a poor prognosis with high mortality despite significant use of resources. Most of the literature to date on this topic has been collected at hospitals with Specialist Liver Units and these results may not be representative of the outcome at general ICUs. A recent prospective study of cirrhotic patients admitted to a tertiary Liver ICU in the UK demonstrated an overall hospital mortality of 59%. The aim of this study was to determine the outcome of cirrhotic patients admitted to non-specialist ICUs.

Methods Data was retrospectively collected from four hospitals in the NW region of the UK without specialist liver ICUs. Patients were identified using the Intensive Care National Audit and Research Unit (ICNARC) database. 61 patients with liver cirrhosis admitted to a general ICU between January 2010 and January 2012 were included in this study.

Results Age range was 30 to 79 years (average 51 years). 80% of patients were male and alcohol was the commonest aetiology for liver cirrhosis (90%). The main reason for admission to ICU was for gastrointestinal bleeding (38%). 51% of patients had a Child Pugh score of C on admission to ICU. 46% of patients had a MELD score between 10 and 19 and 28% had a score between 20 and 29. 79% of patients required invasive ventilatory support, 49% required vaso-pressors and 21% needed renal replacement therapy. 51% developed further decompensation of their liver disease during their ICU stay. These included GI bleeding (21%), hepatic encephalopathy (15%), HRS (11%) and SBP (3%). 67% of patients had an ICU stay of <5 days. A 49% inpatient mortality rate was observed in our study with sepsis and multi-organ failure being the most common causes of death.

Conclusion Patients with liver cirrhosis admitted to general ICUs have similar rates of mortality compared to those in tertiary liver ICUs. Therefore, admission to such units should not be deemed futile in cirrhotic patients and earlier admission may improve outcome.

Disclosure of Interest None Declared

PTU-107 NAFLD IN PATIENTS WITH SEVERE ASTHMA
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Introduction NAFLD is a spectrum of liver disease that encompasses Nonalcoholic fatty liver (NAFL) and nonalcoholic steatohepatitis (NASH). The pathophysiology is not fully understood, but is believed to be a combination of insulin resistance leading to steato-sis and subsequent oxidative injury. Known risk factors include obesity, diabetes and dyslipidaemia.

Severe asthma may entail frequent corticosteroid use and a sedentary lifestyle; both predispose to risk factors implicated in NAFLD. As such we hypothesised a link between asthma and NAFLD, and a possible under detection of NAFLD amongst patients with severe asthma.

Methods We audited the investigation and management of NAFLD amongst patients under the care of the Difficult Asthma Team at the Royal Brompton Hospital. We conducted a retrospective