
An audit of cirrhotic patients managed at the Royal United Hospital demonstrated poor compliance with BSG guidelines, with only 24.1% of eligible patients receiving regular 6 monthly surveillance over an 18 month period. Compliance was particularly poor amongst viral hepatitis patients who often failed to attend appointments.

The current work explores whether the difficulties and inconsistencies noted on a local level are representative of wider practice, and considers ways in which barriers to optimum practice could be overcome.

Methods

Issues raised from a local audit (see above) informed design of an electronic questionnaire which assessed policy, clinician opinion, and response to various clinical scenarios. This was distributed to Gastroenterology/Hepatology consultants and STRs in the South West and Wales.

Results

81 responses were received from 16 NHS trusts across the South West and Wales (42% response rate). 41% of respondents were consultants (59% gastroenterologists/41% hepatologists). 65.3% of respondents were familiar with BSG guidelines, however only 21.8% used them within their institution. 33% of respondents did not know which guidelines their department used.

Widespread variation was noted in response to clinical scenarios. Whereas there was general agreement that 6 monthly surveillance should be afforded to patients with cirrhosis secondary to haemochromatosis and alcohol when abstinent (even amongst females which is not suggested in BSG guidelines), opinion was divided in respect to patients who continued to drink, and in those with non-cirrhotic chronic hepatitis B (47% would offer surveillance, 36% would not).

Poor patient compliance and insufficient resources and expertise to co-ordinate surveillance programmes were cited as the main barriers to successful surveillance. 86% of respondents felt HCC surveillance could be improved within their institution, and 38% thought HCC surveillance programmes should be further extended given recent developments in palliative management.

Conclusion Findings from this study would, if representative of wider practice, suggest considerable variations in HCC surveillance across the UK currently exist. Low levels of compliance with and awareness of BSG guidelines were demonstrated. Opinion regarding optimum surveillance of certain patient groups (e.g., non-cirrhotic viral hepatitis and alcoholic cirrhosis in females) was generally at odds with guidelines. Updating guidelines to account for recent changes in HCC management may help to achieve nationally consistent high quality HCC surveillance. Strategies for improving local HCC surveillance are discussed.

Disclosure of Interest None Declared.