NURSE LED DAY CASE PARACENTESIS
LONG TERM OUTCOMES OF PERCUTANEOUS GUT CASE PARACENTESIS

Refractory ascites is a debilitating condition. Prior to the implementation of nurse led day case paracentesis all patients were admitted into the hospital for an inpatient stay of between 3 and 5 days. An audit of inpatient paracentesis was carried out to assess the quality and efficiency of inpatient paracentesis. From this the service was developed to improve the overall quality of the patient experience and reduce inpatient admissions for paracentesis. Disease aetiology includes alcoholic liver disease, viral disease, autoimmune disease and advanced malignancy.

Methods The hepatologist CNS was trained by the consultant hepatologist to perform paracentesis. All patients requiring paracentesis are referred directly to the CNS from GP’s, out patient clinics and the accident and emergency department. Patients are assessed in a pre procedure clinic by the CNS. A clinical examination is performed, bloods are checked and if necessary corrected accordingly to facilitate day case paracentesis. To date, the CNS has performed over 200 day case paracentesis procedures and complication rates remain below the national average.

Results Data collected from a patient feedback exercise was extremely positive in all aspects of the nurse led day case paracentesis service. An audit of the service demonstrated no difference in overall outcomes when the CNS performed the paracentesis in comparison to the medical registrar. There has been a significant reduction in hospital bed days required for paracentesis.

Conclusion Nurse led day case paracentesis is a safe, effective and economic alternative to costly inpatient hospital admissions. It has proven to be both beneficial to the service user and the NHS trust. Patients benefit from a key worker who specialises in the management of refractory ascites who can provide management and out patient intervention to avoid the potential complications of large volume refractory ascites and unnecessary hospital admissions.

Disclosure of Interest None Declared.

PWE-146
LONG TERM OUTCOMES OF PERCUTANEOUS RECANALISATION FOR BUDD-CHIARI SYNDROME (BCS): OUR EXPERIENCE IN BIRMINGHAM, UK

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Introduction Patients with BCS and short stenosis of the hepatic vein or the upper IVC can be treated with recanalisation by percutaneous venoplasty ± hepatic vein stent insertion. Recent data suggests >60% failure rate (PMID 23389867). We studied the long-term outcomes of this approach in our institution.

Methods Retrospective analysis of patients referred from 1987 to 12/2012 for radiological intervention. Of 161 patients treated for BCS, 60 patients were selected.

Results Median age, 34.5 years (19–65), M:F ratio 23:37. Mean follow up, 8 ± 6.6 years (0.1–26 years), 60% of patients had ≥1 haematological risk factor. Percutaneous recanalisation was technically successful in all patients. The obstruction was at the level of hepatic vein (63%), IVC (6%) and both IVC and HV (6%). 30 patients were managed with venoplasty alone. Of the 30 who had stent placement, 15 had venoplasty prior to stent placements, ranging from 1–11 venoplasty episodes. Due to failure of recanalisation, 26.66% patients required TIPSS (16.7%), surgery (8.3%) and liver transplantation (6.7%). Actuarial survival at 1, 5, 10 was 95%, 93%, and 83% respectively (kaplan meier survival graph). All patients maintained Child's
MINIMAL HEPATIC ENCEPHALOPATHY IS A TRANSIENT ELASTOGRAPHY (FIBROSCANS) SUCCESS
symbol test, the line tracing test (time and errors) and the serial
test were assessed at the bedside. This comprises of a
standardised battery of five paper–pencil psychometric tests:
number connexion test A, number connexion test B, the digit
symbol test, the line tracing test (time and errors) and the serial
dotting test. Minimal hepatic encephalopathy can be diagnosed
when the psychometric hepatic encephalopathy score is less than
-5. This score can be easily obtained by inputting data in an
online tool (http://www.redeh.org/phesapp/datosE.html).

Results
The mean age of the selected cirrhotic patients was 59
± 2.8 years and 74.1% were male. The commonest aetiology
of cirrhosis was alcohol related liver disease (62.9%). 33.3% of
patients were Child’s A, 44.4% were Child’s B and 22.3% were
Child’s C. The mean MELD score was 16.5 ± 9.2. The median
PHES score was 1 (Range -10 to 2). Of the 26 patients evaluated,
7 patients were diagnosed to have MHE (25.9%). The
prevalence varied with the Child’s stage, 11.1% in Child’s A,
25% in Child’s B and 60% of Child’s C patients. All patients
diagnosed with MHE were commenced on Lactulose.

Conclusion
Hospitalised patients with cirrhosis have a significant
prevalence of MHE which is proportional to the stage of
the liver disease. Prompt identification and treatment of this
cohort will help in preventing them from progressing to overt
encephalopathy.

Disclosure of Interest
None Declared.

REFERENCE
1 PMID 23389867. Good long-term outcome of Budd-Chiari syndrome with a step-

PWE-150 TRANSIENT ELASTOGRAPHY (FIBROSCANS) SUCCESS RATES ARE OPERATOR DEPENDENT; EXPERIENCE FROM THE SOUTH WEST LIVER UNIT

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Introduction
Transmit Elastography ( FibroScan® ) is a well validated,
diagnostic test, useful to assess, non-invasive method of assessing the stage of liver fibrosis, whilst avoiding potential complications of liver biopsy. Despite ease of use, operator success rates vary, there is a known failure rate and its accuracy at assessing the stage of fibrosis depends on a ‘valid’ reading being gained. The South West Liver Unit has been performing transient elastography since 2010 and receives referrals from regional hospitals where scanning is unavailable. The aim of this study was to review the overall numbers performed, the success rates of operators, and the percentage of valid scans obtained.

Methods
Data was collected and analysed retrospectively and
was obtained from the FibroScan® hard drive. Clinical information
was obtained from clinical databases and clinical letters. Validation of scan was based on the three recognised validation criteria; (1) >10 valid readings, (2) success rate > 60% and (3) interquartile range to median ratio of < 0.3.

Results Between 2010 and 2012 inclusive, 1819 scans were
undertaken. Multiple attempts ( n = 247), including probe
size change, were excluded. Of the remaining 1572 scans,
(2010 = 537, 2011=554, 2012= 558), 74% were valid on
above criteria (2010=72%, 2011=75%, 2012=74%). Overall
operators performed more scans than nurses, n = 856 versus
n = 713, but nurses had a slightly higher mean success rate,
75.5% vs. 72.5%. Scans were performed by 14 different
operators (registrars, consultants and nurses). Individual
operator success rates varied widely from 43% to 87%; as
did the number of scans performed, median = 70, range
15–373. Success rates were highest in those with formal
training, with a weak correlation to number of scans per-
formed ( r² = 0.34, p=ns). The commonest scan indications
included regional hospital referral (31%), non-alcohol related
fatty liver disease (25%), viral hepatitis (13.5%) and alcohol
related liver disease (11%).