

Abstract PWE-155 Table 1

	Group A (INR 1.1-1.4) n = 25	Group B (INR 1.5-1.8) n = 32	Group C (INR 1.9 and above) n = 1	p value (group A vs B)	p value (group A vs C)	p value (group B vs C)
Blood staining (%)	0	3.1	10	1.00	0.30	0.45
Hypotension (%)	20	9.4	30	0.28	0.66	0.13
Perforation (%)	0	0	0	1.00	1.00	1.00
Leaking site (%)	0	3.1	0	1.00	1.00	1.00
Death (%)	0	0	0	1.00	1.00	1.00
Peritonitis (%)	4	0	0	0.44	1.00	1.00
Infection (%)	0	3.1	0	1.00	1.00	1.00

Conclusion The complication rate does not significantly increase with increasingly deranged coagulation. This is despite very low usage of FFP in this study. There is a trend towards an increased risk of bloodstaining and hypotension in the high INR group, which does not achieve statistical significance.

Disclosure of Interest None Declared.

PWE-156 DURHAM METRICS TO EVALUATE EFFECTIVENESS OF A NEW CARE PATHWAY FOR PATIENTS WITH ADVANCE STAGE LIVER DISEASE (ASLD)

¹S Saksena*, ²L Hammal, ³C Lancaster, ⁴M Hewett. ¹Hepatology, Durham, UK; ²County Durham Darlington Foundation Trust, Durham, UK

10.1136/gutjnl-2014-307263.416

Introduction Patients with chronic liver disease have several unplanned admissions during their disease trajectory.¹ We undertook a service improvement initiative to develop a new care pathway for patients with ASLD.

Methods Six month pilot of 20 ASLD patients, (≥ 2 admissions in last 12 months/would you be surprised question' with 6-12 mths prognosis/Childs C). Team of hepatologist, community matron, hepatology nurse specialist and service improvement facilitator developed 'Durham Metrics': quantitative and qualitative metrics (Figure) to evaluate ASLD pathway, on best practice,² further refined with focussed discussion with stakeholders.

Results The metrics demonstrated that patient experience pre-pilot was poor with multiple unplanned admissions and/or long

waits, preferred place of death was not discussed; care was not co-ordinated, and quality of life was often poor as a result. All post-pilot metrics reported significant improvements. Use of alternative community services, and shared care plans led to improved efficiency. 83% achieved their preferred place of care and death contrast to nil pre pilot.

Conclusion Key metrics of performance are essential to evaluate service improvement project. The project metrics designed for this project were able to capture changes initiated by pathway however more data and time is needed to draw statistically valid conclusions.

REFERENCES

- 1 National End of Life Care Intelligence Network 2012
- 2 Deciding Right
- 3 Liver Quest

Disclosure of Interest None Declared.

PWE-157 EARLY TIPS (TRANSJUGULAR INTRAHEPATIC PORTOSYSTEMIC SHUNT) FOR ACUTE VARICEAL BLEEDING COMPLICATING ALCOHOLIC HEPATITIS (AH)

¹S Alam*, ¹E Britton, ²U Shaikh, ²J Evans, ¹P Richardson. ¹Gastroenterology, Royal Liverpool University Hospital, Liverpool, UK; ²Radiology, Royal Liverpool University Hospital, Liverpool, UK

10.1136/gutjnl-2014-307263.417

Introduction The ideal management of variceal bleeding in the setting of acute alcoholic hepatitis is unclear. We present the outcome of this subgroup of patients in a cohort of patients treated with primary TIPS for variceal bleeding.

Methods A retrospective analysis on patients who had TIPS procedure performed as a primary treatment modality within 72 h of acute variceal bleeding from December 2010 to April 2013 with a minimum of 6 months follow up was performed.

Results 56 patients were included into the final analysis. In AH patients (n = 18) mean age was 48 years (30-65), mean discriminant function (DF) was 51 (24-87) and mean MELD score was 22. The 6 month mortality was 50% (9/18) with (7/9) dying within 30 days. The median HVPG (mmHg) pre-TIPS and post-TIPS were 16.5 and 6.5 respectively. In non-AH patient (n = 38) average age was 51y (25-70) mean MELD score was 14 (22-7). The mortality was 13% (5/38) at 6 months, (3/5) died by day 30. The median HVPG (mmHg) pre-TIPS and post-TIPS was 23 and 10 respectively.

Conclusion In patients with variceal bleeding complicating AH there is a higher 30 day and 6 month mortality in patients managed with a primary TIPS in comparison to patients with cirrhosis. The ideal management of this complex group remains unclear.

Disclosure of Interest None Declared.

Durham Metrics for Evaluating ASLD Service	Patient 1		Patient 2		Patient 3		Patient 4	
	Before	After	Before	After	Before	After	Before	After
Best Outcome								
Registered on GP Palliative Care Register (y/n)								
Care Management Plan in place (y/n)								
- Emergency Health Care Plan in place (y/n)								
- Advance Care Plan discussed (y/n)								
Preferred Place of Care - individual care wishes discussed and known (y/n)								
DNACPR in place & following patient throughout pathway (y/n)								
Best Patient Experience								
Key point of contact known within community services (y/n)								
Patient has chosen and discussed preferred place of care (y/n)								
Patient information offered/available to support self-management (y/n)								
Quality of life & living with ASLD (patient story) - Questionnaire/Interview (y/n)								
Patient story outcome - broadly positive (P) or broadly negative (N)?								
Best Efficiency								
Total number of admissions for ASLD (total admissions)								
No. unplanned admissions (sub-set of total admissions)								
No. re-admissions within 30 days (sub-set of total admissions)								
No. of admissions for Abdominal Paracentesis (sub-set of total admissions)								
Total length of stay (all admissions for ASLD, incl. Cirrhosis)								
Total length of stay for Abdominal Paracentesis (sub-set of total length of stay)								
Guidelines in place to support paracentesis in non-acute care settings (y/n)								
Best Employer								
Skills & knowledge - gaps & training needs of Trust staff known								
Relevant training materials produced to meet skills/knowledge gaps								
Pro-active ASLD case management - resource gaps in primary/community care known								

Abstract PWE-156 Figure 1