

Na fell in 34/60 patients (57%) and was less likely if baseline hyponatraemia existed (38% VS 74% $p = 0.004$). A fall of $\geq 5\text{mmol/l}$ occurred in 23%.

Median time to nadir Na was 3 days and time to recovery to pre-treatment Na was 6.5 days. No complications of hyponatraemia were observed.

Patients with VB were more likely (vs HRS patients) to have any fall in Na or a $\geq 5\text{mmol/l}$ reduction (68% vs 47% $p = 0.1$ and 32% vs 16% $p = 0.12$ respectively) but failed to reach significance.

Mortality was 22% overall and a fall in Na was actually associated with reduced mortality –9% vs 34% ($p = 0.01$).

Conclusion Serum Na falls in >50% receiving terlipressin and a fall $\geq 5\text{mmol/l}$ noted in 23%.

However, no significant complications occurred and a fall in serum Na was actually associated with improved mortality. Patients with VB treated with terlipressin trended towards a greater likelihood of Na reduction versus those with HRS.

Disclosure of Interest None Declared.

PTU-111 DETERMINING CEILING OF CARE IN DECOMPENSATED CIRRHOSIS – RIGHT DECISIONS, RIGHT PEOPLE, RIGHT TIME

B Hudson*, H Morrison, FH Gordon, CA McCune, PL Collins, AJ Portal. *Department of Hepatology, University Hospitals Bristol NHS Trust, Bristol, UK*

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Introduction Decisions to initiate intensive care measures in patients with decompensated liver cirrhosis are often controversial, with mortality approaching 90% in cirrhotics with 3 organ failure. The 2013 NCEPOD report ‘Measuring the Units’, which examined alcoholic liver disease-related deaths, nonetheless found that 31% of those who stood to benefit from higher level care did not receive it. We studied escalation of care decisions and subsequent outcomes in cirrhotic patients with organ failure.

Methods Consecutive patients with a diagnosis of cirrhosis admitted over a 90 day period in 2013 to the Bristol Royal Infirmary were studied. Severity of liver disease was assessed using Childs-Pugh and UKELD. Organ failure was defined using SOFA (Sequential Organ Failure Assessment) criteria. Care escalation/withdrawal decisions were assessed in respect to timing, seniority and expertise of decision maker. Outcome measures of ICU admission, mortality and instigation of palliative care were recorded.

Results 42 admissions for 37 patients (ages 16–79, 79% male, 81% related to alcohol, 22% Childs A, 54% Childs B, 24% Childs C) were scrutinised. 30% had suffered variceal haemorrhage on, or during, admission. Of 17 patients admitted in organ failure, ICU admission was requested on 8 occasions (6 by a hepatologist, 1 during out of hours admission, 1 following out of hours deterioration). Escalation plans had been discussed with ICU prior to the point of clinical deterioration in 50%. 3 patients were accepted to ICU for mechanical ventilation, of which none survived. 1 patient was accepted in principle but improved clinically. 4 patients were declined ICU admission on grounds of poor prognosis, all of whom had alcoholic cirrhosis. Of this group all required non-invasive ventilation, with 75% surviving to discharge. Across the entire cohort 55% of hepatologist led “for full escalation if required” decisions were agreed in principle with ICU. 33% of ICU decisions to withdraw care were discussed with the referring hepatologist. Of the 7 patients who died overall, 4 were on an end of life tool with appropriate palliative measures in place.

Conclusion The high survival rates in patients refused intensive care, and high mortality amongst mechanically ventilated

patients highlight the complexities of predicting outcomes in this population. Despite this, discussions between hepatology and ICU regarding ceiling and withdrawal of care often did not occur until the point of clinical deterioration, risking delays to escalation of care or appropriate palliation. Strategies to ensure early escalation decisions involving senior hepatologists and intensivists should be developed to ensure appropriate care is afforded to all cirrhotic patients in a timely fashion.

Disclosure of Interest None Declared.

PTU-112 ASSOCIATIONS BETWEEN HEALTHCARE RESOURCE UTILISATION AND HEALTH-RELATED QUALITY OF LIFE IN CIRRHOSIS

¹J Orr*, ²T Homer, ²L Ternent, ²L Vale, ¹M Hudson, ¹D Jones. ¹*Institute of Cellular Medicine, Newcastle University, Newcastle Upon Tyne, UK;* ²*Institute of Health and Society, Newcastle University, Newcastle Upon Tyne, UK*

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Introduction Cirrhosis is associated with impaired Health-Related Quality of Life (HRQoL) and considerable resource use. The association between healthcare utilisation and HRQoL in cirrhosis has not been previously studied.

Methods Four HRQoL tools (SF-36v2, CLDQ, PBC-40 and PROMIS-HAQ) and a healthcare utilisation tool were completed by patients with cirrhosis. Associations between resource utilisation and HRQoL were explored; means were compared using unpaired t tests.

Results 108 patients have been recruited to the study to date with completed tools received from 73. Regular care was required by 29 (40%) with 15 (21%) requiring help with personal care, 12 (16%) with medical care, 18 (25%) with meal preparation and 21 (29%) with housework. All types of care were associated with significantly impaired HRQoL across all domains of all measures tested ($p < 0.05$). The total number of healthcare consultations (hospital consultations + GP consultations + nurse consultations) was also related to HRQoL with patients who had five or more consultations in a 2 month period showing significant impairment compared to patients with fewer than five consultations. Specifically there was evidence of poorer physical HRQoL with mean SF-36 Physical Component Summary (PCS): 32.5 ± 9.0 vs 40.6 ± 10.6 , $p = 0.001$ and functional restriction evidenced by PROMIS-HAQ: 42.2 ± 26.9 vs 21.1 ± 25.2 , $p = 0.001$. In addition, patients with more consultations had poorer social HRQoL with SF-36 Social Functioning (SF): 31.3 ± 12.3 vs 40.2 ± 12.8 , $p = 0.005$ and PBC-40 social: 36.3 ± 9.9 vs 30.0 ± 9.7 $p = 0.01$.

Conclusion The need for any type of regular care and more frequent consultations with healthcare professionals are associated with poorer HRQoL in cirrhosis.

Disclosure of Interest None Declared.

PTU-113 A REGIONAL AUDIT OF THE MANAGEMENT OF PATIENTS WITH DECOMPENSATED LIVER DISEASE

¹J Dyson*, ^{1,2}S McPherson on behalf of North East, North Cumbria Clinical Hepatology Network. ¹*Liver Unit, Freeman Hospital, UK;* ²*Institute of Cellular Medicine, Newcastle University, Newcastle Upon Tyne, UK*

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Introduction The recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report ‘Measuring the Units’ found that hospitals are missing opportunities to save the