Na fell in 34/60 patients (57%) and was less likely if baseline hyponatraemia existed (38% vs 74% p = 0.004). A fall of ≥5mmol/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 ≥5mmol/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 ≥5mmol/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.
lives of people with alcohol-related liver disease (ARLD) by failing to provide early intervention and specialist consultant input.†

Methods We aimed to review the management of patients with decompensated liver disease in the first 24 h after admission to hospital. This was a region-wide audit including all trusts in the Northern Deanery. An audit proforma was designed and data collected on consecutive admissions over a 3 month period.

Results 139 patients were included in the study; 69% male, median age 54 years (range 26–86 years). ARLD was the cause of liver disease in 88%. The median MELD score was 19 (range 6–39) and 88% had Child-Pugh Grade B or C disease. The commonest reasons for admission were ascites (28%), GI bleeding (21%), encephalopathy (19%) and jaundice (16%).

There was a 9% mortality rate during the admission and average length of stay was 15 days.

82 patients had clinical ascites; 62% had a diagnostic tap within 24 h of admission, 21% waited >24 h and 17% did not have a diagnostic tap. 18% had spontaneous bacterial peritonitis (SBP).

Previous alcohol history was only documented in 43% but current daily consumption was documented in 81%. Of patients with documented current alcohol excess, 92% received parabines and 94% were started on CIWA.

99% had their renal function checked on admission. 26% had renal impairment; 28% of whom did not have all their nephrotoxins stopped. Hyponatraemia (sodium <125 mmol/L) was present in 9%; 42% of whom did not have diuretics stopped.

27 (19%) patients had known or suspected variceal bleeding. 19% did not receive terlipressin and 30% did not receive vitamin K. 67% of patients had an upper GI endoscopy within 12 h of admission, and 78% within 24 h.

Hepatic encephalopathy was present in 32% of patients and lactulose commenced in 98%.

17% of patients were not seen by a consultant (any specialty) within 12 h of admission, 7% were not seen by a gastroenterology or hepatology consultant within 72 h of admission and 39% were not seen within 24 h.

Conclusion There are clear deficiencies in the acute management of patients with decompensated liver disease across the Northern region in keeping with the findings of the NCEPOD report. The findings of this audit will be shared across the region in keeping with the findings of the NCEPOD report. The aim of this study was to apply these scoring systems demonstrated an AST:ALT ratio >0.8 in 32 (46.4%), APRI >0.51 in 20 (30.0%) and FIB-4 >1.46 score in 14 (20.3%), 11 (15.9%) had high scores across all 3 indices.

Introduction Hyperlipidaemia is a recognised risk factor for the development of non-alcoholic fatty liver disease (NAFLD). Aspartate aminotransferase (AST):alanine aminotransferase (ALT) ratio, AST-to-Platelet Ratio Index (APRI) and Fibrosis-4 (FIB-4) scores are validated, indirect, non-invasive methods which can be employed to exclude the possibility of hepatic fibrosis in the context of NAFLD.1 The aim of this study was to apply these indices to patients attending a lipid clinic, with an elevated ALT to determine what proportion would merit further hepatology assessment.

Methods We performed retrospective analysis of patients attending a lipid clinic in a university teaching hospital from 2011–2013. None of the patients were under gastroenterology/hepatology follow-up. In those with elevated ALT (>30 IU/L male, >19 IU/L female) we calculated the AST:ALT ratio, APRI and FIB-4 scores.

Results 130 patients were included (68 male, 62 female; mean age 54 (17–93)). Platelet data was available for 113 patients and 69 (53.0%) had elevated ALT (52% male). In these patients the scoring systems demonstrated an AST:ALT ratio >0.8 in 32 (46.4%), APRI >0.51 in 20 (30.0%) and FIB-4 >1.46 score in 14 (20.3%), 11 (15.9%) had high scores across all 3 indices.

Conclusion We have demonstrated that a significant proportion of patients with lipid abnormalities and raised ALT may be at risk of NAFLD with fibrosis. By using a composite of these scoring systems it may be possible to identify those who would