received solid organ or bone marrow transplants and take immunosuppressive drugs, a chronic or persistent hepatitis can develop defined by viremia for greater than 3 months. Spontaneous clearance can occur with reduction of immunosuppressive load. Failing this, there is evidence these patients can be successfully treated with ribavirin. The goal is sustained viral response (SVR) with undetectable Hepatitis E RNA in blood and stool for 6 months after treatment. A recent analysis of 69 patients with solid organ transplants reported SVR of 78%. Some success has also been seen in bone marrow transplants. We aim to present our experience of treating persistent Hepatitis E infection with ribavirin.

Methods Retrospective analysis of clinical records and the pathology database.

Results Following a screening program at the Queen Elizabeth Hospital, Birmingham we have treated 11 transplant recipients with ribavirin over the last 18 months. Transplant types included 4 liver, 3 kidney, 1 heart and kidney combined and 3 bone marrow. The median age of the cohort was 44, patients were a median of 2 years out from transplant and taking a median of 2 immunosuppressants. ALT was raised in all patients, median value 155 (46 to 599). Ribavirin treatment was given for 12 weeks and continued if stool remained RNA positive at week 12; the median course was 14 weeks. Ribavirin was generally well tolerated although one patient had a treatment break at 2 weeks due to diarrhoea and vomiting; 2 needed EPO support. SVR was observed in 10/11 patients (91%) of whom 9/10 (90%) have continued to show SVR until the present time (mean 2.2 months). ALT responded in all patients, median value 20 (11 to 31). One patient did not achieve SVR and relapsed at 3 months; one patient who did achieve SVR relapsed at 10 months. 2 bone marrow recipients had received high dose steroids for graft versus host disease (GvHD) and liver biopsy was undertaken to distinguish Hepatitis E from GvHD: in both cases the biopsy showed a non-specific chronic hepatitis in keeping with Hepatitis E.

Conclusions Our Results show SVR of 91% with ribavirin in persistent Hepatitis E infection in a diverse cohort with different types of transplant including bone marrow. The fact that all patients had abnormal ALT means that persistent Hepatitis E must be considered as a cause of raised liver enzymes in transplant recipients. Of particular interest is the need to distinguish GvHD from persistent Hepatitis E in bone marrow recipients as the therapeutic approaches are fundamentally different and increasing doses of steroids, and rituximab in one case, led to worsening viral loads in our cohort. Ongoing follow-up will take place in our cohort and look for late relapse.

ADWE-05 PRE-EMPTIVE TIPSS IMPROVES CLINICAL OUTCOMES IN PATIENTS WITH VARICEAL HAEMORRHAGE: A RETROSPECTIVE COHORT STUDY

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Variceal haemorrhage is a medical emergency associated with a 30 day mortality of 15% and a re-bleeding rate of 26%. If there is failure to control bleeding endoscopically salvage TIPSS is reported to control bleeding in 90%–100% of cases,

with re-bleeding rates of 6%–16%. However mortality remains high. Approximately 20% of patients are 'high risk'; here early or pre-emptive TIPSS, before treatment failure (up to 5 days post bleed), can significantly reduce morbidity/mortality. A recent multicentre study has shown that pre-emptive covered TIPSS was associated with good outcomes but poses significant challenges in the 'real world' situation. We evaluated the clinical outcomes of patients undergoing a covered TIPSS following an acute variceal bleed and subsequent admission to the Intensive Care Unit with focus on pre-emptive TIPSS strategies.

Method We used the CRIS Radiology Information System to construct a database of all patients undergoing a TIPSS for variceal haemorrhage at between 2013 and 2016. For each patient we collected a wide range of data, which were analysed using SPSS (SPSS Inc. Chicago IL, USA) and expressed as means±SD. Mortality data were analysed using the Kaplan-Meier Method.

Results We studied 96 patients with a mean age 51.0±12.1 years, M:F ratio (67:29), alcohol related liver disease (59.4%), MELD score 15.8±6.8, and follow up 25.4±18.3 months. All TIPSS procedures were successful, and indication was as salvage (42%), pre-emptive (44%), and secondary prevention (14%). Initial management involved band ligation in combination with vasoconstrictors and/or Sengstaken-Blakemore Tube in all cases. Patient mortality at 6 weeks, 6 months, 12 months and 24 months was 19%, 24%, 30% and 34% respectively. MELD score >15 was significantly associated with mortality following multivariate analysis. Six week mortality was significantly higher with salvage TIPSS compared to pre-emptive strategy (33% versus 9%, $p<0.05$), even after controlling for MELD. There was no difference in mortality between pre-emptive and secondary prevention strategies. The overall re-bleeding rate was 2%.

Conclusion The outcomes of patients admitted to ICU following a variceal bleed are good and comparable to published literature. This is probably a reflection of high-standard ICU care. Pre-emptive TIPSS up to five days following the index variceal bleed Results in significantly better outcomes than salvage TIPSS, with mortality comparable to TIPSS for secondary prevention. However, the currently hub and spoke model of TIPSS services in the UK is unable to accommodate a pre-emptive strategy in all region

PWE-073 SPLEEN STIFFNESS VIA ACOUSTIC RADIATION FORCE IMPULSE IN HIV PATIENTS WITH NON CIRRHOTIC PORTAL HYPERTENSION

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Introduction Several HIV centres describe small cohorts of patients with non-cirrhotic portal hypertension (NCPH). Didosine (ddI) exposure has been associated and the optimal monitoring and management of these patients remains unclear. Non-invasive assessment of the spleen is now being utilised to assess splenic stiffness in cirrhotic portal hypertension and predict outcomes. This technique has not previously been studied in patients with HIV and NCPH.

Methods Acoustic Radiation Force Impulse (ARFI) elastography was performed using Philips EPIQ7TM to simultaneously assess

liver and spleen stiffness in 3 patient groups. Group 1: HIV and NCPH, defined as the presence of portal hypertension manifestations in the absence of cirrhosis; Group 2: HIV and past ddi exposure (without known NCPH); Group 3: HIV and no history of liver disease. Groups were matched for age, HIV chronicity and antiretroviral treatment (including cumulative ddi exposure in Groups 1 and 2). Clinical and demographic information was collected. Differences in liver and spleen stiffness (in kPa) between groups were analysed using the Mann-Whitney U test

Results 25 patients were recruited (Group 1: n=11, Group 2: n=5, Group 3: n=9). Patients were well matched for age, HIV chronicity and all had HIV RNA levels <20 copies/mL. Cumulative ddi exposure in Groups 1 and 2 was 56 and 53 months respectively (p=0.91). Median (IQR) ARFI liver and spleen stiffness in Group 1, 2 and 3 was 5.5 (4.8–9.8), 4.3 (4.0–5.3) and 4.8 (3.8–5.2) kPa (p=0.031) and 46.3 (29.5–143.2), 21.3 (14.6–26.8) and 18.3 (14.6–21.6) kPa (p=0.001) respectively. Liver and spleen stiffness were both significantly higher in NCPH vs ddi-exposed (p=0.019 and p=0.005) and ddi-unexposed controls (p=0.038 and p<0.001). Spleen stiffness was more effective than liver stiffness at predicting NCPH, AUROC 0.812 vs 0.948. Combining the two variables improved the diagnostic performance, AUROC 0.961. The optimal cut-off for predicting NCPH using splenic stiffness was 25.4 kPa, with sensitivity 91%, specificity 93%, PPV 91%, NPV 93%, positive likelihood ratio 12.73, negative likelihood ratio 0.10. Spleen and liver stiffness scores were strongly correlated (p=0.0004 95% CI 18, 59).

Conclusions Elevated spleen stiffness is observed in HIV patients with NCPH and can be quantified easily using ARFI with high diagnostic accuracy. Novel strategies such as ARFI for longitudinal monitoring of patients with HIV and NCPH should be considered.

PWE-074 HOSPITALITY DISCHARGE FOR ALCOHOL RELATED PROBLEMS IN NORTH OF ITALY: A SIXTEEN – YEARS PERIOD

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Background and aims WHO (2014) estimates a remarkable decline in per capita pure alcohol consumption in Italy, dropped from 18.1 to 7.1 lt in the period 1970–2013. Despite this, Italian Report on Alcohol 2016 showed an increase in drinking outside meals and a rise in consumption and binge drinking among young people (18–24, 14–17), particularly in males. The impact of these drinking styles on hospitalisation is still under-researched. This study aims to evaluate the trends of hospitality discharge for alcohol-related liver disease in the period 2000–2016 in Veneto Region in North Eastern Italy (4.8 million inhabitants).

Method Retrospective cohort analysis based on Veneto Region anonymous computerised database of hospital discharges between 2000 and 2016. All Veneto residents discharge records with principal diagnosis of alcohol-related liver disease (cod. ICD9-CM: 571.0, 571.1, 571.2, 571.3) were included in the study. The principal diagnosis was chosen as it is considered the primary reason for hospital admission. Standardised Hospitalisation Ratio (SHR) per five-year age group (ref.

pop. Veneto 2008) was calculated and expressed per 100.000 population.

Results Over the period 2000–2016, 28.968 hospital admissions for alcohol-related diseases were recorded. Most part of subjects were males (74%) with a SHR more than double compared to females (53.3 vs. 18; OR:2.96; CI 95%:2.89–3.04 p<0,05). The longitudinal analysis of the hospitalisation trend shows a 7% increase on average age in both sexes (from 58.8±9,2 to 62.6±9,6) and a substantial decrease of 66% in SHR (X2 trend: 3933,326). In the last year of observation SHR tends to 19.5, and the greater risk for males is confirmed (30.2 vs. 8.8; OR:3.51; CI 95%:3.05–4.10; p<0.05). Considering the age groups, the highest decline in SHR can be found in the ranges 45–64 (from 69.2 to 34.1) and >65 (from 69.3 to 26.8). Interestingly, SHR shows a slightly rising trend in the group 25–44 between 2013 and 2016 (p<0.05).

Conclusion In Veneto Region, the reduction in alcohol intake over the last 30 years has lead to a marked decrease in hospitalisation for alcohol-related diseases. However, the changes in drinking styles occurred in the age range 25–44 may explain the upward SHR trend between 2013 and 2016. Thus, in the next few years it is likely to expect an increase in hospitalisation in this age group. Public Health strategies are needed to address the new styles of alcohol consumption, especially in young people.

Abstract PWE-074 Figure 1

PWE-075 MANAGING NAFLD VIA A MULTIDISCIPLINARY CLINIC APPROACH IMPROVES LIVER HEALTH AND IS COST EFFECTIVE

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Introduction Non-Alcoholic Fatty Liver Disease (NAFLD) is the hepatic manifestation of metabolic syndrome and is tightly associated with type 2 diabetes (T2DM). Management centres around weight loss and therapies for diabetes and