Conclusions Prior to a dedicated hepatologist the vast majority of those presenting with AVB have a history of previous AVB and are potentially avoidable. With the advent of dedicated banding lists (as well as closer follow up with more robust secondary prophylaxis) there has been a major reduction of AVB presenting. There has been a shift of ‘new’ AVB unknown to the system rather than previous existing patients having undergone prior therapy. This has equated to a significant reduction in AVB of 30% during period 1% and 56% during period 2. Dedicated ‘surveillance’ lists such as for Barrett’s have shown to reduce the incidence of late presentation of disease and we propose that dedicated varices surveillance and banding lists can reduce acute admissions.

Conclusions Survetence was associated with earlier stage cancers and receipt of potentially curative treatment. However, patients known to secondary care made up a minority of HCC diagnoses. Improving identification and diagnosis of cirrhosis in primary care may therefore help identify at-risk patients earlier, although not all patients will engage with follow-up.

AFP measurement may identify additional cases of HCC that go undetected by USS, but should be weighed against potential patient harms from false-positive Results. Further studies should continue to inform an optimum HCC surveillance strategy.

### PTH-090 SURVIVAL AFTER A DIAGNOSIS OF HEPATOCELLULAR CARCINOMA

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Introduction Survival estimates for different Barcelona Clinic Liver Cancer (BCLC) stages in hepatocellular carcinoma (HCC) contained in the EASL-EORTC Clinical Practice Guidelines rely on outcomes from randomised control trials and meta-analysis of pooled data. To identify areas for development to facilitate improvements in outcomes we aimed to provide an insight into HCC survival outcomes outside a clinical trials setting by presenting a large experience of patients with HCC to a regional hepatobiliary cancer centre in the UK.

Methods All patients referred to the Hepatobiliary Cancer Multidisciplinary Team with a diagnosis of HCC over a two year period (January 2013 to December 2014) were included. Patients were stratified by their initial treatment modality according to the BCLC classification, Kaplan-Meier survival analysis was used to compare outcomes by initial treatment allocation.

Results Among 356 patients (median age 66 years, 291 (82%) male), the most frequent underlying disease aetiologies were hepatitis C and alcohol-related liver disease. Overall survival at 3 years after diagnosis was 38% and 146 patients (41%) received treatment with curative intent. The 3 year survival for liver transplant was 84% (56 patients) and for resection was 89% (46 patients). The median survival for radiofrequency ablation was 45 months (44 patients) and for transarterial chemoembolization (TACE) it was 18 months (72 patients). For patients receiving sorafenib as first-line therapy, the median survival was 9.6 months (12 patients) and for those receiving best supportive care (BSC) it was 3.4 months (126 patients).

Conclusions These estimates of overall survival are consistent with those published in the EASL-EORTC Clinical Practice Guidelines and demonstrate that these figures give a reliable estimate of overall survival in a real-world experience. Over one third of patients were unsuitable for anti-cancer therapy at presentation and only a minority received treatment with curative intent. This highlights areas for potential improvement in outcomes particularly through early diagnosis of cirrhosis, facilitating treatment of the underlying cause of liver disease as well as the implementation of surveillance for HCC. Screening strategies for cirrhosis should be investigated to determine whether these can reduce overall mortality, including that from HCC.