Abstract PTH-106 Figure 2

Conclusions Plasma S100A8/A9 is significantly elevated in ACLF, correlating strongly with activation of pro-inflammatory mediators and indices of disease severity, extra-hepatic organ failure and outcome. Our in vitro data indicate that this mediator promotes inflammation and represents a novel therapeutic target in ACLF.

Abstract PTH-107

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Introduction Non-alcoholic fatty liver disease (NAFLD) has become a major public health issue with an increasing prevalence worldwide. Accurate diagnosis and staging of the disease is important in determining the long-term management and follow-up of these patients. The aim of our study is to investigate the correlation between non-invasive tests and different stages of liver fibrosis in NAFLD.

Methods 905 patients with NAFLD underwent Fibroscan at Aberdeen Royal Infirmary from March 2013 to November 2016. 417 patients with liver stiffness measurement >7 kPa underwent electronic medical record reviews to identify patients who had liver biopsies within a year from the date of their Fibroscan. 54 out of 417 patients underwent liver biopsies. 42 of the 54 patients were identified to have biopsy-proven NAFLD. The histological reports of the liver biopsies were reviewed and different stages of fibrosis were recorded. Liver fibrosis was classified as no fibrosis (F0), mild fibrosis (F1), moderate fibrosis (F2), severe/bridging fibrosis (F3) and cirrhosis (F4). Clinical, radiological and biochemical data of these patients were also analysed, provided they were within 1 year from the dates of liver biopsies.

Results Out of the 42 patients identified, the mean age was 56 (±14) with a male preponderance (55%). 1 patient had no fibrosis (F0), 14 patients had mild fibrosis (F1), 1 patient had moderate fibrosis (F2), 14 patients had severe fibrosis (F3) and 12 patients had cirrhosis (F4). Correlation between different variables and stages of fibrosis were tested using the non-parametric Spearman’s correlation coefficient. Data are summarised in the table 1 below and are expressed as median ±IQR.

Abstract PTH-107 Table 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Fibrosis Stage</th>
<th>Correlation Coefficient (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F0-F1 (n=15)</td>
<td>F2-F3 (n=15)</td>
</tr>
<tr>
<td>Liver stiffness measurement (LSM) kPa</td>
<td>10.1 (±5.8)</td>
<td>21.3 (±5.5)</td>
</tr>
<tr>
<td>NAFLD Score</td>
<td>0.64 (±2.67)</td>
<td>0.28 (±1.65)</td>
</tr>
<tr>
<td>APRI Score</td>
<td>0.6 (±0.13)</td>
<td>1.13 (±0.67)</td>
</tr>
<tr>
<td>Fibrosis-4 Score</td>
<td>1.26 (±1.84)</td>
<td>2.66 (±2.14)</td>
</tr>
<tr>
<td>UKELD Score</td>
<td>46 (±2.5)</td>
<td>47 (±2)</td>
</tr>
</tbody>
</table>

Conclusions Our study indicated that there were statistically significant positive correlations between LSM, NAFLD score and FIB-4 score with different stages of fibrosis in patients with NAFLD. However, the correlations between AST to Platelet Ratio Index (APRI), United Kingdom Model for End-Stage Liver Disease (UKELD) score and different stages of fibrosis were not statistically significant. The difference may be due to the inclusion of clinical variables in the NAFLD score. The addition of LSM to the NAFLD score could potentially improve the diagnostic accuracy of fibrosis in NAFLD patients.

Abstract PTH-108

THE OUTCOME OF TRANSARTERIAL CHEMOEMBOLIZATION FOR LIVER CANCER PATIENTS IN ABERDEEN ROYAL INFIRMAKY

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Introduction Hepatocellular carcinoma (HCC) is the 5th most common cancer worldwide, it often presents in advanced stages with limited treatment options, reflected in its poor prognosis. Transarterial chemoembolisation (TACE) is an
established palliative treatment for patients with advanced HCC, but outcomes vary. In this retrospective observation study, we assessed radiological response and survival outcome following TACE in a single large centre.

**Methods** Data was collected between October 2013 and December 2017 for all TACE procedures at Aberdeen Royal Infirmary by access to MDT records and radiological data. Basic demographics, aetiology and severity of underlying liver disease, lesion characteristics (number and size) and Barcelona staging (BCLC) were all recorded. Scans were reviewed by two consultant radiologists and modified RECIST criteria used to assess the radiological response (complete response: disappearance of all target lesions; partial response: minimum 30% decrease in sum of the longest diameter of target lesions).

**Results** 31 patients underwent TACE procedure (1 excluded due to loss of follow up). Mean age 68.5±7.33, 76.6% were male and 29/31 White British. All procedures used doxorubicin loaded beads. The main aetiologies were non-alcoholic fatty liver disease 11 (36%), Alcohol-related liver disease 10 (33.3%), hepatitis C virus 5 (16.6%), 86.7% had underlying liver cirrhosis. BCLC staging of patients was 12 (40%) A, 17 (56.6%) B, 1 (3.4%) C. 8 patients (26.6%) had TACE as a bridge for transplant or tumour resection.

A CT scan 6 weeks post-procedure showed 7 patients (23.3%) complete response while 19 patients (63.3%) had partial response, only 4 patients (13%) had no response. Of the 11 patients with a single tumour lesion <5 cm, 8 (72.7%) had complete response and 3 (27.3%) partial response. During the median follow up time of 17 months (1–41), 8/30 patients had progression of the same liver lesion (33.3%) while 11 (36.3%) developed new liver lesions, and 5 (16.6%) distant metastasis. 11 (36.3%) patients died during the follow up period, 3 (27.3%) had a small initial tumour lesion. Mortality rates at BCLC stage A was 5/12 (41.6%) and B 5/17 (29.4%). Of the 8 using TACE as a bridge to curative treatment, 3 underwent liver transplant, 2 remain active on transplant list, 1 underwent surgical resection and 2 were removed from the list. There were no major complications noted post TACE procedures.

**Conclusions** TACE helps to improve the survival and downstage HCC to allow curative treatment options. Only a small number had no radiological response to TACE. Those with initial BCLC B appeared to have a better survival, likely due to smaller numbers in stage A group. Those with a single tumour lesion less than 5 cm showed the best radiological response rate and survival.

**PTH-110 ‘SAVE MY LIVER DOC, USE THE CARE BUNDLE!’**

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**Introduction** The first 24 hours is the most crucial timeframe for reducing morbidity and mortality in patients with decompensated liver cirrhosis and the use of the Cirrhosis Care Bundle in the first 24 hour has been shown to improve clinical outcomes in several tertiary centres across the UK. Our aim was to introduce the Cirrhosis Care bundle on the Medical Acute Unit (MAU) to improve the care of patients with decompensated liver cirrhosis.

**Methods** Two prospective audit cycles were conducted between Nov 2016 to April 2017. In each cycle, we prospectively reviewed all patients admitted with decompensated liver cirrhosis on the MAU. The first audit cycle was conducted between Nov to Dec 2016. Following which, several teaching sessions were organised to educate the MAU staff and doctors on the Cirrhosis Care bundle, one of which was delivered by Consultant gastroenterologist. Paper copies of the Cirrhosis Care bundle were also made available in the MAU.