Improving end of life care for patients with liver disease

Sam Thomson1, Kim Batchelor2, Stephen Kriese3, Suzanne Ford-Dunn3. Western Sussex Hospitals NHS Foundation Trust, Worthing, UK; St Barnabas House Hospice, Worthing, UK.

Objectives To improve the care and care planning for patients with end stage liver disease (ESLD) and to ascertain preferred place of death.

Methods We conducted a third audit cycle of MDT activity after introducing the ESLD care bundle. We reviewed patient needs, coordinated care and initiated referrals to additional community services and ESLD CNS. Patients referred to the ESLD CNS received holistic assessment with advanced care planning and contingency plans for future acute decompensation events.

Results In the first 12 months of the new MDT there were 43 deaths with ESLD in our locality, 60% in hospital, 37% in community (home/hospice); contrasting to 73% and 26% nationally, 79% of all patients were known to PC at the time of death. Of 22 patients that expressed a preference for place of death, 11 chose home and 11 hospice; none preferred to die in hospital. Of 22 patients under the ESLD CNS in the community, 73% died out of hospital (7 home, 9 hospice). 68% of patients under the ESLD CNS died in their preferred place of care. Of 26 who died in hospital 30% died on the acute medical unit, 0% died on the gastroenterology ward and the remainder (40%) on outlying wards.

Conclusions Most patients with ESLD prefer to die out of hospital, consistent with other terminal illnesses. Although ESLD patients present a challenging symptom burden it appears that an MDT approach including a dedicated CNS can help increase referrals to PC, and help more patients die in their preferred place. However, a third of those dying in hospital did so in an acute environment or while receiving intensive care and therefore were unlikely to have received adequate PC. A notable number also died on non-specialist outlying wards which may imply they too did not receive wholly integrated specialist or PC during their terminal phase. Although the preliminary Results of our local intervention are promising, we recognise that more can still be done and encourage a continued focus on improving end of life support and care planning for patients with ESLD.
linked by a common source of transmission or a shared behaviour and that this link could be demonstrated by phylogenetic analysis.

**Methods**
A case definition of men, aged 35–75, presenting with acute HBV, with no recorded risk factors, was adopted. The PHE Database ‘HP zone’ was used to compile a line list of new acute HBV matching the case definition within the undisclosed county, from January 2012 to January 2015. Inclusion criteria for all cases required HBV core IgM positive status with clinical symptoms or biochemical markers consistent with acute hepatitis. Data on risk factors was compiled, as part of routine investigation, from the PHE acute HBV questionnaire using open and focussed questioning. Serum specimens on the line list were sent to the PHE laboratory, Colindale for phylogenetic analysis.

**Results**
33 cases of acute HBV were identified with 19 men fitting the case definition. The line list was expanded to include the remaining 7 men aged 35–75 in the same region and timeframe who did report risk factors for HBV exposure (total=26). 6 cases did not have stored serum for genotyping. 17 cases of HBV Genotype A2 were identified, 14 met the exact case definition with no risk factors with the remaining 3 reporting high-risk sexual activity with men. 3 Cases of Genotype D were identified, all of which reported risk factors. 14 of the 19 cases that fitted the definition described themselves as heterosexual and married at the time of diagnosis. All spouses tested negative for HBV.

Of the 17 A2 genotypes 16 were 99%–100% identical and 12 were 99.7%–100% identical at the nucleotide level with one case differing by a single base pair at the HBsAg region. All cases were of a single, stable strain known as the ‘Prisoner Variant’, which has increased in prevalence from 1990, primarily in the prison population of north England.

**Conclusions**
The genotypic link of at least 16 cases with a non-prevalent strain of HBV indicates a common source of infection. The lack of confirmed risk factors in so many cases may indicate a shift in the ‘epi-picture’ with new behaviours making at-risk groups harder to identify for targeted health-education or vaccination. The cluster remains active with further cases being investigated.

---

**Abstracts**

**PTH-113**

**THE SUCCESS OF KAFFES STENT INSERTIONS FOR POST LIVER TRANSPLANT ANASTOMOSTIC STRICTURES**


Institute of Liver Studies, King’s College Hospital, London, UK

10.1136/gutjnl-2018-BSGAbstracts.269

**Introduction**
Biliary anastomotic strictures (AS) occur in around 30% of patients following liver transplantation and are treated by endoscopic dilatation and plastic stent (PS) insertion. However, AS frequently recur and patients require multiple procedures. The Kaffes stent (KS, Taewoong Medical) is a removable, covered metal stent designed to be deployed across AS.

**Methods**
To examine outcomes in patients with AS, we compared a recent cohort of patients treated using KS with a historical cohort of patients who received PS.

**Results**
The 22 patients (12 females) treated by KS had mean age 55 (range 22–69) years; 11 patients had DBD and 11 DCD grafts; mean cold ischaemia time was 9.6±3.3 hours. Four patients had failed previous treatment with PS. To date, 16 patients have had KS removed. The 69 patients (20 female) treated by PS were similar, mean age 51 (range 28–79) years; 47 patients had DBD and 22 DCD grafts; mean cold ischaemia time was 8.9±3.1 hours.

AS resolved after one deployment of KS in 14 out of 16 patients (88%) compared to 26 out of 69 patients (38%) receiving their first PS (Relative Risk of persistent stricture (KS vs PS)=0.2, 95% CI 0.05–0.74; p=0.016; number to treat by KS for one benefit=2, 95% CI 1.3–4.0). There were no complications, including stent migration, after KS compared to 6 (8.4%) in the PS group (3 cholangitis, 2 pancreatitis, and 1 bleeding). All KS were removed successfully, although 1 stent needed 2 attempts because of wire migration. Following initial ERCP, PS patients required more ERCPs (mean 2.71 vs 1.13 more; p<0.01) and 32% required biliary reconstruction.

**Conclusion**
Our data indicate that the KS is a promising Method for managing post-transplant AS because the majority of strictures are treated by deployment of a single stent at first ERCP.