Abstract OTU-09 Figure 1

B and C) presenting with oesophageal variceal bleeding (VB), following initial haemostasis with endotherapy and drugs. However, this is based on a single randomised controlled trial (RCT).

Methods An open-label, parallel-group, RCT was performed at 2 experienced UK centres. Cirrhotic patients with a Childs Pugh (CP) score ≥ 8 presenting to either centre with VB were considered for inclusion in the study. Following haemostasis with endoscopic band ligation (EBL) and vasoactive drugs, consenting participants were randomised to either continued EBL $\pm$ non-selective beta-blockers (standard care) or early-TIPSS (ie within 72hrs). All patients were followed up for 1 year, or until death. The primary endpoint was survival at 1 year. Secondary endpoints included early and late re-bleeding (<6 weeks and 6 weeks - 1 year). The study was completed between April 2012 – January 2018.

Results 216 patients were screened with 58 eligible participants ultimately included (29 per group). EBL and early-TIPSS were well matched for age (53.9 vs 49.4); CP score (10.1 vs 9.8); and MELD score (16.8 vs 16.4) respectively.

On intention to treat, 1-year survival rates were 75.8% in the EBL group versus 79.3% in the early-TIPSS group ($p=0.79$) (see figure 1). 1 patient in the EBL group received TIPSS as rescue therapy, but later died. 4 patients who were randomised to early-TIPSS did not receive this intervention due to time delays and therefore underwent standard care. However, on per-protocol analysis, no survival benefit was observed between groups ($p=0.85$). In patients with Childs-Pugh C cirrhosis ($n=33$) no difference in survival was seen between groups ($p=0.81$). At 6 weeks, rebleeding occurred in 2 patients in both the EBL and early-TIPSS groups. At 1-year, rebleeding occurred in 8 patients in the EBL group compared with 6 patients in the early-TIPSS group. No significant differences in rates of rebleeding were seen at the specified time points. Additionally, no significant differences were observed between the two treatment groups with respect to serious adverse events.

Conclusions Contrary to the previous study, our findings do not support the use of early-TIPSS in the reduction of mortality or rebleeding in patients with cirrhosis who are hospitalised for acute variceal bleeding. Given the challenges of resourcing the widespread provision of early-TIPSS, further multi-centred studies with larger patient numbers are required to resolve this important issue.

OTU-10 IMPACT OF CIRRHOSIS SEVERITY ON CLINICAL OUTCOMES IN HEPATOCELLULAR CARCINOMA IN ENGLAND

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10.1136/gutjnl-2019-BSGAbstracts.201

Background Survival in hepatocellular carcinoma (HCC) is determined by both cancer stage and severity of underlying liver disease. International guidelines based on data from clinical trials provide a benchmark for survival following different HCC treatments [1]. The aim of this study was to estimate the impact of cirrhosis severity on overall survival for patients with HCC and cirrhosis in England.

Methods All patients registered with a new diagnosis of HCC between 2007 and 2016 in England were identified from the National Cancer Registration and Analysis Service records, which are linked to the Hospital Episode Statistics dataset. These records were used to identify patients with cirrhosis, their baseline characteristics and HCC treatments received. Cirrhosis severity at HCC diagnosis was categorised by the Baveno IV consensus: compensated cirrhosis defined by stage 1 (no ascites or varices) and stage 2 (non-bleeding varices), and decompensated cirrhosis defined by stage 3 (ascites) or stage 4 (bleeding varices).

Following HCC treatment, the linked record was analysed to identify subsequent decompensation events during 5 years of follow-up. Competing risk models were used to describe the risk of death after decompensation ('death due to liver failure') and the risk of death without decompensation ('death due to HCC').

Results Among 19,436 patients registered with HCC, 11,337 were identified with cirrhosis and were included in the analyses. The majority of patients (6,207, 54.7%) were ineligible for specific HCC treatment and received best supportive care. The most common HCC treatments were ablation (1,228 patients, 10.8%) and trans-arterial chemoembolization (TACE; 2,021 patients, 17.8%).

Among those who received ablation, the median survival was 41.9 months in those without varices at HCC diagnosis, 33.8 months in those with non-bleeding varices, and 23.9 months in those with previous decompensation ($P<0.001$). Among those who received TACE, median overall survival in