sustained virological response (cure) 12 weeks post treatment. 2 patients failed to achieve a cure. 17 patients are still on treatment or have not yet reached 12 weeks post treatment to assess for cure.

From July to September 2017 49 patients were tested for blood borne viruses in the needle exchange. 21 were HCV antibody negative and 28 antibody positive. Of the 28 HCV antibody positive patients 15 were HCV antigen positive thus having active HCV infection and were referred for treatment. For the 3 month period at the end of the retrospective look back exercise 33 patients were tested; 25 were negative and 8 HCV antibody positive but no patients had HCV antigen positivity. 5 patients were referred to the clinic following disclosure to needle exchange staff that they had previously tested HCV positive in another service or area.

Conclusions Chaotic HCV patients can be successfully treated in the community where outreach services can be offered alongside harm minimisation services. Treating active IVDUs is achievable and can have an impact on the local prevalence of HCV amongst small chaotic communities.

Abstracts of Distinction

ATU-06 DOES THE TIMING OF TIPSS IN PATIENTS WITH ACUTE OESOPHAGEAL VARICEAL BLEEDING ALTER PATIENT OUTCOME?

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10.1136/gutjnl-2019-BSGAbstracts.207

Introduction International guidelines recommend consideration of early-TIPSS (<72hrs) for high-risk patients presenting with oesophageal variceal bleeding (OVb). This advice follows a single randomised control trial reporting significant survival benefits of early-TIPSS in such patients. However, with the challenges of resourcing the widespread provision of early-TIPSS, we aim to determine if the time taken to carry out TIPSS alters patient outcome.

Methods This is a single centre cohort study of prospectively collected data in patients undergoing covered TIPSS following urgent (<12 hrs) endoscopic band ligation (EBL) for acute OVb between October 1998 - October 2014. Indications for progression to TIPSS include: failed haemostasis at index endoscopy; clinical evidence of further bleeding after haemostasis at index endoscopy; high risk of rebleeding after haemostasis at index endoscopy. Patients were defined by 2 groups; 'early-TIPSS' being those undergoing TIPSS ≤72 hours of index endoscopy, and 'late-TIPSS' being >72hrs. Primary outcome is all cause mortality. All cases were followed up from the date of OVb necessitating TIPSS insertion for a minimum of 4 years or until death/liver transplant.

Results 281 patients were included in the study with 199 undergoing early-TIPSS and 82 having late-TIPSS. Analysis was carried out on 70 patients in each group following propensity score matching. For early and late TIPSS respectively, there were no statistical differences between age (51.2 vs 54.0), female sex (31.4% vs 35.7%), Childs Pugh (CP) score (10.3 vs 10.0), MELD (16.8 vs 18.1), rates of ascites (71.4% vs 65.7%) or encephalopathy (31.4% vs 28.6%) on admission, portal pressure gradient fall (15.1 vs 14.9), rates of post-TIPSS encephalopathy (28.6% vs 24.3%) and rebleeding (24.3% vs 20%). Using competing risk analysis, median follow-up days were as follows: Early TIPSS dead: 259, alive: 5503, liver transplant: 651; Late-TIPSS dead: 322, alive: 5134, liver transplant: 172. Equality of cumulative incidence function across groups was non-significant and there was no statistical significance in the incidence of death between the two cohorts (figure 1). On multivariate competing risk regression analysis for the outcome of death, MELD, CP score, ascites and post-TIPSS rebleeding were all statistically significant predictors.

Conclusions To our knowledge this is the largest real-world study, with the longest follow-up times, carried out on patients undergoing TIPSS following urgent endoscopic treatment for acute OVb. With advanced statistical analysis, our data suggest that timing of TIPSS does not alter survival in this group of patients.

Abstract ATU-06 Figure 1