steatosis grade ($P = 0.001$). By plotting receiver operating characteristic (ROC) curve, the sensitivity and specificity of plasma *MIR17HG* protein in determining the extent of hepatic fibrosis (early vs. advanced) were 92.9% and 93.7% respectively at a cut-off value of 40.3 pg/ml (AUC = 0.978) and were superior to those of APRI (78.6% and 62.5% respectively at a cut-off value of 1.37, AUC = 0.857) and FIB-4 score (85.7% and 81.2% respectively at a cut-off value of 1.61, AUC = 0.902).

Conclusion Plasma *MIR17HG* protein could be a potential simple biomarker for determining the severity of hepatic fibrosis in chronic HCV infection and its decrease in relation to fibrosis regression after direct-acting antivirals needs to be evaluated.

PTU-004 HEPATOCELLULAR CARCINOMA CAN BE MANAGED SAFELY AND EFFECTIVELY IN A DGH-SETTING WITH SUPERIOR SURVEILLANCE-PROGRAMME SURVIVAL

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Introduction and aims HCC is the second commonest cause of cancer-related death worldwide and strongly associated with liver cirrhosis and with a rising incidence.

Despite screening most HCC cases present at an intermediate or advanced stage unsuitable for curative surgery. The standard of care for most non-curative cases being actively treated remains transarterial chemo-embolisation TACE and/or ablation (RFA.) Both are specialist procedures normally delivered in tertiary centres.

At the Royal Bournemouth Hospital (RBH), a large DGH, specialist HCC treatments are offered to Dorset County following MDT and combined hepatology/IR clinic review. There is an established surveillance programme offered to all suitable at-risk patients.

We sought to assess the outcomes of the service with a focus on the benefits of surveillance and the safety of offering tertiary level services in a DGH setting.

Methods We identified all new HCC cases presented in the pan-Dorset Upper GI MDT from Jan 2017 to Dec 2017. We collected demographic data, whether they had been under a surveillance programme and the treatment outcomes including complications and 1- and 12- month mortality.

Results We identified 35 patients (30 M; 5F.) The aetiology was alcohol in 26% (n=9), NASH 43% (n=15), HCV 17% (n=6) and others 9% (n=3.) Cirrhosis was present in 63% (n=22): Child's A 59% (n=13), Child's B 32% (n=7) & Child's C 9% (n=2.)

Most cases were referred from RBH 77% (n=27), and 23% from the two other referring hospitals in the County. HCC surveillance detected 43% (n=15) of cases with 57% new presentations. Of the surveillance cases, the majority 87% (n=13) were identified at the centre with the most established surveillance programme but as the largest centre RBH also identified most new presentations 70% (n=14.)

More active treatment was offered to the surveillance group at 87% vs 65% of non-surveillance group ($p \leq 0.05$.)

Curative treatment (transplant, surgery or RFA to small HCC) was suitable in only 14.3% (n=5), all identified by surveillance.

TACE was offered to 46% of patients (n=16.) Of the TACE patients, 56% (n= 9) underwent more than 1 procedure. Only 2 patients had decompensation post-TACE, which recovered. Post-TACE survival was 100% at 1 month and 79% at 1 year. These outcomes are comparable to published literature from larger centres.

Overall 1-month and 12-month survival for surveillance cases was better than new presentations at 100% and 73% vs 85% and 50% respectively ($p \leq 0.05$.)

Conclusions Specialist HCC treatment, following combined hepatology/IR review, can be offered safely and effectively in a large DGH setting with mortality and morbidities outcomes comparable to specialist tertiary centres. Our data confirms HCC surveillance allows for earlier cancer detection with more treatment options and improved survival.

PTU-005 REDUNDANCY OF ELASTOGRAPHY IN MONO-INFECTED HCV INDIVIDUALS <30 YEARS OLD- SIMPLIFICATION OF TREATMENT ALGORITHMS

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Introduction The Hepatitis C Virus (HCV) is a blood-borne, causing chronic infection, defined as the persistence of HCV RNA for at least 6 months after initial infection. Chronic HCV infection predisposes individual patients to liver fibrosis, cirrhosis and hepatocellular carcinoma. Of those with chronic HCV infection; it is estimated that 16–20% of individuals will go on to develop liver cirrhosis within 20 years.

There has been a revolution in the treatment of chronic HCV infection with almost universal cure. The issue is now to minimise the steps required to initiate treatment; especially as we seek to treat younger, more difficult to engage individuals. Currently, fibrosis is assessed before starting treatment. We sought to validate the theory that those individuals who were mono-infected with HCV; young and with no additional hepatic insult were unlikely to have significant fibrosis.

Methods We performed a retrospective analysis of the Tayside Hepatitis C dataset; with collation of relevant basic demographics including age, sex and baseline Fibroscan® measurements pre-treatment. Previous validation of transient elastography (TE) in HCV has suggested that a cut off of less than 11 kPa would exclude significant fibrosis.

Results Our complete cohort consisted of 719 individuals with HCV who had elastography performed before undergoing HCV therapy. We stratified for age across 5 year intervals. The results are summarized in the figure below.

Abstract PTU005 Figure 1

Age Range	Total (n=) (M/F)	Transient Elastography (Mean; Range)	Transient Elastography >9 kPa	Transient Elastography >11 kPa
<30 Years	99 (62/37)	5.71 (3.2–10.6)	1	0
30–35	111 (82/29)	8.9 (2.1–26.6)	6	4

Within this patient cohort we established that no patient under 30 had a TE score > 9 kPa without a co-existent