bundle was poor. Following this study, we plan to implement a care bundle systematically to further evaluate patient outcomes.

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PTU-015 NATURAL HISTORY OF VARICES IN THE ERA OF NON-INVASIVE ASSESSMENT

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Introduction Guidelines recommend endoscopic variceal screening and surveillance in patients with cirrhosis.¹ The rate of development of large oesophageal varices needing treatment appears to be 7–8% per year.^{2,3} However, with a growing proportion of diagnoses also now being made by Fibroscan we hypothesize that this rate may be lower.

Methods We performed a case note review of 304 patients with a liver stiffness measurement (LSM) more than 15 kPa on Fibroscan between April 2012 and February 2016. Patients also had to have an endoscopy within 6 months to be included. We excluded patients with previous decompensation, hepatocellular carcinoma, inaccurate LSM (IQR >30%) or LSM felt to be aberrant by the clinician based on clinical, radiological or histological grounds. For patients with hepatitis C (HCV) we used post-SVR LSM. We recorded sex, age, aetiology of liver disease, LSM, platelet count, endoscopic findings at 0–6 months and at 24–48 months, duration of follow-up, incidence of bleeding or death. Varices were documented as absent, small or large.

Results 113 patients were included. The most common aetiologies were non-alcoholic fatty liver disease (36.2%), alcoholic liver disease (29.3%) and HCV (20.7%). Mean age was 59.3 ± 11.5 years. LSM was 33.4 ± 17.1 kPa. Median follow-up was 4 years. Baseline endoscopy revealed no varices in 76 patients (67.3%), small varices in 29 patients (25.7%) and large varices in 8 patients (7.1%). 6 of the patients (5.3%) had a variceal bleed within 12 months. All large varices underwent band ligation (VBL) as per local practice. 58 patients went on to have a repeat endoscopy at 24–48 months. There was no progression of absent/small varices in 50 patients (86.2%) and a static gastric varix in 1 patient (1.7%). There was progression to large varices in 7 patients (13.8%) including 1 variceal haemorrhage.

Conclusions In our group of patients with compensated cirrhosis the rate of development of clinically significant varices over 3 years appears to be lower than previous estimates. Weaknesses of the study include its retrospective nature and drop out rate. However, the findings would fit with our perception of an increased rate of diagnosis of advanced chronic liver disease by Fibroscan. The natural history of varices may be different to historic populations diagnosed on histological grounds or overt clinical and radiological features.

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PTU-016 EFFECTIVENESS OF A NURSE-LED FIBROSCAN SERVICE TOWARDS ENHANCED CARE IN LIVER DISEASE

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Introduction and aims Fibroscan as a convenient, non invasive tool for classification of Liver Stiffness (KPA) and fat component (CAP) has gained popularity in the hospital as well as community health services. With burden of liver disease significantly affecting the NHS in terms of finances as well as mortality, an accurate measure of the liver parenchyma assists in delivery of safe enhanced care. We present our nurse led fibroscan service in comparison to conventional modalities in the management of liver disease.

Methods 273 patients were referred to the Nurse led Fibroscan service from July 2017–July 2018. The Fibroscan readings were then compared to the Ultrasound scan (USS), biochemistry and liver biopsy results. British Society of Gastroenterology (BSG) guidelines were then used to appropriately escalate or de-escalate these subjects.

Results Out of 273 patients referred 30 were excluded due to difficult procedures.

Out of 243 screened, 52.68% were female. An average age of 53.9 years was seen (Median 55, IQR 19). The Fibroscan results were classified into Normal, Fatty Liver, Fibrosis and Cirrhosis based on KPA and CAP as per the manufacturer guideline for different etiology. Average Alanine transaminase (ALT) of 49.22 was seen

Fibroscan results showed Normal = 24 (9.87%), Fatty Liver = 122 (50.2%), Fibrosis = 54 (22.2%) and Cirrhosis 43 (17.69%) and compared to USS.

Of the 48 subjects who had Normal USS, 22 showed fatty liver, 9 had fibrosis and 2 had cirrhosis on fibroscan showing a 68.75% (n=33) variance in diagnosis indicating a worsening stage of liver disease.

Of the 123 that had fatty liver on USS, 81 had the same diagnosis on fibroscan too. There was variance in 34.14% subjects (n=42) with 3 showing a better diagnosis having Normal fibroscan and 23 and 16 subjects showing fibrosis and cirrhosis respectively, indicating a worsening diagnosis. As per BSG guidelines, fatty liver disease and ALT of below 50 can be discharged back to the care of GP. 63 (51.2%) of these patients were hence safely discharged in this manner.

70 subjects had Cirrhosis on USS, 11 were normal on fibroscan, 14 showed fatty liver and 20 showed fibrosis indicating the variance to be 50% (n=45) towards a favourable prognosis.

The total variance in diagnosis was noted in 122 (50.2%) of the subjects from USS to fibroscan, with 41% (n=50) having a better stage and 72 (59%) showing worse stage of disease.

44 of these subjects underwent liver biopsies which correlated to the above findings in similar percentage.