Most patients had normal biochemical liver profiles, with mean values for bilirubin $18.2 \pm 10.6 \mu\text{mol/L}$, ALT $26.5 \pm 10.6 \text{ IU/L}$, albumin $47.5 \pm 5.3 \text{ g/L}$ and platelets $169 \pm 55 \times 10^9$, despite hepatic imaging of parenchymal abnormalities. Two patients were found to have hepatocellular carcinomas (HCC), BCLC stage B and C at diagnosis. There was a total of 4 deaths over a median follow-up of 2.8 years, of which 2 deaths were liver-related.

Conclusions Elevated hepatic stiffness and ultrasound appearance in keeping with severe fibrosis are common in adult Fontan patients, despite normal liver enzymes and synthetic function. FNH is the most common abnormality on imaging in high risk patients. The incidence of HCC justifies surveillance in this group of patients, however the optimal surveillance protocol remains to be established.

PTU-038 END OF LIFE CARE PLANNING IN PATIENTS WITH END-STAGE LIVER DISEASE: CLINICAL PRACTICE REMAINS VARIABLE

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10.1136/gutjnl-2019-BSGAbstracts.247

Introduction End-stage liver disease (ESLD) is a terminal diagnosis without transplantation, and anticipatory discussions regarding end of life (EoL) care are appropriate when poor prognostic factors are present.

Aim To assess the point at which decisions regarding resuscitation and EoL care were made with patients who died of ESLD and to analyse factors associated with delayed discussion.

Methods We identified inpatients with proven ESLD under the care of a hepatology team over a 24 month period (Jan 2017-Dec 2018) who died during or shortly after their last admission. Data was collected relating to clinical course, prognostic indicators, EoL care planning considerations, dates of DNACPR decision, palliative care referral and interval to death.

Results 19 patients were identified (12 male: 7 female); mean age at death was 61. 11/19 patients had alcoholic liver disease (ALD), 5 had ALD/Hepatitis C. 12 patients died on the ward, 3 in ICU, 2 at home and 2 at a nursing home. Child-Pugh Scores (CPS) ranged from B-6 to C-13 and average MELD score was 23 (range 8–38). None were eligible for transplantation: 12 due to active alcohol use, 3 due to co-morbidities, 1 malignancy, 2 unknown. Median number of admissions in the year preceding death was 2 (range 0–5). Predominant symptoms prior to death were respiratory distress, confusion and pain. Average interval between admission and death was 24 days. 13/19 patients were referred for inpatient palliative care input. Although all patients had a DNACPR notice in place, the average DNACPR-to-death interval was just 20 days (range 0–139 days). EoL decisions were made 'early' (DNACPR-to-death time >21 days) in patients (n=6) who had gradual disease evolution and/or a long period of contact with the service. In those with 'short' DNACPR-to-death times (n=13), 9 had been hospitalised 2 or more times in the year prior to death (this being a known marker of poor prognosis), and 2

had been admitted 4 or 5 times. 5/19 patients had a documented Amber Care Bundle referral (prognostic uncertainty tool). 14 patients had a documented ceiling of care discussion; of these 12 were for ward-based care only and 2 were for Level 3 escalation.

Conclusions Patients with end stage liver disease continue to be engaged in EoL and treatment escalation discussions relatively late, despite clear indicators of poor prognosis (including recurrent admissions and non-transplantable status) within the previous year. Those well known to specialist teams who deteriorate gradually have a greater chance of expressing their preferences. Increased awareness of poor prognostic features is required in the secondary care setting.

PTU-039 THE COST-EFFECTIVENESS OF HEPATITIS B AND C TESTING IN EMERGENCY DEPARTMENTS IN THE UK

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10.1136/gutjnl-2019-BSGAbstracts.248

Introduction The prevalence of blood borne viruses is higher in emergency department (ED) attendees compared to the general population, due to higher attendance of marginalised populations. Studies have found prevalence up to 2% and 3% for hepatitis B (HBV) and hepatitis C (HCV) in EDs in England. HIV testing in EDs in the UK is recommended in high prevalence areas ($\geq 0.2\%$), but there is no defined threshold for hepatitis testing.

Methods A Markov model was developed to analyse the impact of opt-out hepatitis C (HCV) and hepatitis B (HBV) testing in EDs in the UK. The model used data from studies of ED testing in the UK to parameterise test costs and intervention effects (contact rates and linkage to care). For HCV we used an antibody test cost of £3.64 and RNA test cost of £68.38, and assumed a direct acting antiviral (DAA) treatment cost of £10,000. For HBV, we used a HBsAg test cost of £3.51. We considered what prevalence of HCV (RNA-positive) and HBV (HBsAg) would be required to make ED testing

Abstract PTU-039 Figure 1