PTU-086 VIRTUAL BIOLOGICS CLINIC FOR IBD PATIENTS- IMPROVING PATIENT AND SERVICE EXPERIENCE

Emily Creed*, Katie Clark. *St Helens and Knowsley Nhs Trust, Prescot, UK*

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Introduction Increasing demand on outpatient services, increased use of high cost drugs and the desire to involve patients more in their own care led to the introduction of a virtual multidisciplinary clinic for patients with inflammatory bowel disease (IBD) at a large district general hospital. The key drivers were to standardise and enhance pre-biologic screening and monitoring, to collect accurate, real-time data to enhance national audit, to realise service and cost efficiencies yet still provide a service that remains acceptable to our population.

Methods We sent questionnaire to our patients, gauging current opinion on the service and their thoughts on a virtual clinic (would it meet needs, would they accept this type of review) and achieved a 45% response rate. We also performed a pilot clinic of 20 randomly selected patients with IBD on biologic drugs and collected data related to screening, and whether a virtual clinic would work within the broader goal of a treat-to-target strategy for these patients. From the positive response, the clinic was established comprising a consultant Gastroenterologist, IBD nurse and pharmacist.

Results The clinic has been established for almost 12 months. In that time:

1. We have established a robust, easy to maintain database that directly links to the data required for the IBD Registry. The database can also be utilised by our research team to identify appropriate patients for clinical trials.

- 50 patients have had their biologic treatment stopped due to biochemical remission with only 3 out of those requiring further treatment.
- 34 patents have had their medication switched in a timely manner due to early identification of non or lack of response (mean time 35 days)
- Cost savings have returned to the CCG
- Patients report they are 'highly satisfied' with the service as they know their treatment is under regular review without the need for additional hospital visits.

Conclusions The virtual biologics clinic provides a robust, standardised review for all IBD patients on high cost drugs without impacting on already overstretched outpatient clinic capacity. In addition to significant cost savings to the CCG, improved data collection and participation in national audit; the service is acceptable to the patients and is now an integral part of the IBD service.

PTU-087 SPECIALIST MDT CLINIC MANAGEMENT IMPROVES ACCEPTANCE RATES AND POST-TRANSPLANT RELAPSE IN PATIENTS WITH ARLD

¹Michael Ding*, ¹Charlotte Parker, ¹Jennifer Towey, ¹Matthew Harborne, ¹Chiemelie Ngonadi, ¹Malik Magrabi, ¹Laurence Hopkins, ²Anya Mohideen, ²Abbie Harrison, ²Jon Catling, ^{1,3}Neil Rajoriya, ^{1,3}Andrew Holt. ¹The Liver Unit, Queen Elizabeth Hospital, UK; ²The School of Psychology, University of Birmingham, UK; ³Both authors contributed equally

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Introduction Alcohol-related Liver Disease (ArLD) is the most common indication for liver transplantation (LT) in the UK (30%) but many patients are deemed physically or psychologically unsuitable at the time of LT assessment and post-LT alcohol relapse rates remain high (1–2% Kawaguchi *et al.* 2014). A specialist high intensity ArLD clinic was established to optimise patient's pre-LT assessment from a medical, addiction, psychological and nutritional perspective and evaluate high risk patients assessed for LT within a specialist MDT clinic environment. The clinic comprises of 2 Transplant Hepatologists, addiction psychiatry specialists, liver dietician & researchers.

The aim was to review the impact of the high intensity clinic programme in patients transplanted for complications of ArLD cirrhosis.

Methods Data was reviewed retrospectively from all patients attending clinic from inception, 25/5/2016- 31/9/2018. Electronic notes and alcohol addictions/transplant databases were interrogated. Patients were contacted anonymously (independent from health practitioners) by Psychology researchers for follow-up psychological data.

Results 261 patients were seen, 247 (seen pre-LT) were included for analysis (173M: 74F), mean age 54y (SD ± 19.65), UKELD=53 (SD ± 5.63). 124 (50%) were presented in the transplant listing meeting, 71 (57.25%) accepted. 46 underwent LT at time of analysis, median waiting list time=39d [range 3–373]. 11/247 attendees (4%) had documented relapse within the programme pre-LT.

54/247 (21.9%) were referred to the high intensity clinic after being turned down by the transplant listing meeting, considered physically or psychologically unsuitable. Of these, 59.3% were re-presented after further intervention and subsequently listed. Of all attendees, 54 deaths (21.9%) were recorded on follow-up (2 on the LT waiting list & 4 post LT).

Follow-up questionnaire completion rate was 78% (32/41) demonstrating high levels of patient engagement. Patient satisfaction with the clinic was high. Median follow-up post-LT was 13mo [range –8.4]. Post-transplant relapse in this high risk group managed in the high intensity clinic was 0/46 (0%)–vs 6/49 (12.2%, $p < 0.05$) in a historical post-LT ArLD group (201–9) not seen in the high intensity clinic ($n = 49$ contacted from 68 transplanted, 72%).

Conclusion The High Intensity MDT clinic is an effective clinical environment for treating high risk patients and managing their physical and psychological risk factors. Specialist addiction-focussed MDT management enables patients who were initially deemed unsuitable for transplantation to be listed for surgery and is shown to significantly reduce short term relapse in this cohort of patients.

PTU-088 DAY CASE ELECTIVE PARACENTESIS

Hannah Dix*, Miss Heather Cracknell, Elaine Henry, Morag Barron. *NHS Tayside, Perthshire, UK*

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Introduction Increasing prevalence of chronic liver disease has caused demand for elective paracentesis in refractory ascites to exceed capacity in NHS Tayside, with patients diverting to acute care areas. Assessing the current elective care pathway

has allowed us to develop the service in order to increase capacity, reduce pressures on unplanned care and reduce costs. **Method** 12 weeks of prospective data were collected on patients receiving elective paracentesis. Recommendations made on analysis of this data (Excel) led to changes in the standard operating procedure and a further 6 weeks of prospective data collection closed the PDSA cycle.

Results In the initial data collection, 31 elective paracentesis were completed on 15 individual patients. Drains were in situ for a median of 24 hours, necessitating an overnight stay. On average 10,966ml of fluid were drained (range 4324ml – 19692ml). The rate of ascitic drainage plateaued at 8 hours, with an average, 74% (range 53%-100%) of total ascitic fluid drained at this point. From this we hypothesized that adequate drainage could be achieved with a day case procedure.

During the second data collection, 27 elective paracentesis were completed on 12 individual patients with drains in situ for 8 hours. On average 8,123ml of fluid were drained (range 3903ml – 20996ml). If we extrapolate this data over 12 weeks we could accommodate a 74% increase in capacity between study groups.

20% albumin replaced 4.5% to reduce volume infused, therefore reducing further time constraints on admission. On average 3 bottles of 4.5% albumin were used in the initial study group and only 2 bottles of 20% in the second study group. This led to a cost saving, on average of £57.06 per paracentesis, this becomes substantial when added to the cost savings of day case versus overnight stay.

There were no clinically significant changes in renal function or haemodynamic parameters in either data set. 86% of patients initially studied had a UKELD score greater than 49 with a median value of 54.5 (range 4–0).

There were 7 repeat attenders in the initial group and 4 in the second, attending 3 and 4 weekly, respectively. Only one patient was studied in both data sets with increased drain frequency from monthly to fortnightly.

Conclusions Both data sets have shown variability of ascitic fluid volume and drainage rates. We must continue an individualised approach to refractory ascites, but changes to our standard operating procedure have increased elective paracentesis capacity by 74%, reduced pressure on unplanned care and reduced costs by £793.06 per paracentesis. The changes are safe with no clinically significant renal function or haemodynamic deterioration. It is difficult to attribute cause to changes in paracentesis frequency given the multiple confounding factors related to ascites production.

PTU-089 HEPATITIS B SCREENING PRIOR TO RITUXIMAB AND SUBSEQUENT MANAGEMENT TO REDUCE THE RISK OF REACTIVATION

¹Grace Dolman*, ²Ioannis Theocharopoulos, ¹Patrick Kennedy. ¹Barts Liver Centre, London, UK; ²Barts and the London School of Medicine and Dentistry, London, UK

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Introduction Hepatitis B (HBV) reactivation can occur during immune suppression in patients with serological evidence of current infection (HBsAg positive) or past exposure to HBV (HBsAg negative, anti-HBc positive). Rituximab poses a particular risk, with reported rates of reactivation >10% in those with positive HBV markers. Reactivation can result in delays

to ongoing treatment and, in small numbers of cases, acute liver failure leading to transplantation or death.

Methods We performed a retrospective audit of screening for HBV markers prior to rituximab and management of patients at risk of HBV reactivation in an East London NHS Trust serving a multi-ethnic population. Our cohort was identified from a search of electronic records for a pharmacy order for rituximab placed in 201–018 across clinical specialties.

Results 461 patients were included, of whom 191 were male (41%). Ethnicity was as follows: British or Irish 169 (36.6%); Asian or Asian British 118 (25.6%); Black or Black British 44 (9.5%); Any other white background 44 (9.5%); Mixed 4 (0.9%); Chinese 1 (0.2%); Any other ethnic group 22 (4.8%); Not known 59 (12.8%). Screening was adequate in 384 patients (83.3%). 62 patients (13.4%) had undetectable HBsAg, but no record of anti-HBc. 2 patients (0.4%) were not tested for HBsAg, but were anti-HBc negative, making past/current infection unlikely. 13 patients (2.8%) had no record of either HBsAg or anti-HBc testing. 339 patients (72.7%) had undetectable HBsAg and anti-HBc. 3 patients (0.7%) tested positive for HBsAg, all of whom received appropriate antiviral prophylaxis. 42 patients (9.1%) tested positive for anti-HBc, with undetectable HBsAg. It was probable that passive transmission had occurred as a result of immunoglobulin infusions in 2 cases and was confirmed in 3 cases. Repeat anti-HBc was pending in 2 patients. 5 of these 7 patients received antiviral prophylaxis. Anti-HBc positivity was thought to be due to past HBV exposure in 35 patients (7.6%). One patient was already on Truvada for HIV infection. A further 27 patients received antiviral prophylaxis with either lamivudine, entecavir or tenofovir, although in 7 of these the prophylaxis commenced after rituximab infusions had started. No prophylaxis was given to 8 patients at risk of HBV reactivation based on serological markers (21% of at risk group). There were no episodes of reactivation during the audit period.

Conclusion In this audit of a multi-ethnic population receiving rituximab, we found that screening was adequate in only 83% of cases. Of those adequately screened, nearly 10% were at risk of hepatitis B reactivation with B-cell depleting therapies. 21% of those at risk did not receive appropriate prophylaxis. We propose cross-specialty guidelines and safety checkpoints in pharmacy and infusion units to reduce the risk of HBV reactivation in this patient group.

PTU-090 THE USE OF FAECAL CALPROTECTIN AS A SCREENING TOOL FOR REFERRING PATIENTS WITH POSSIBLE IBD

Darren Fernandes*, Aarati Mathew, David Elphick. Chesterfield Royal Hospital, Chesterfield, UK

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Introduction Faecal calprotectin (FC) has been shown to have high sensitivity and specificity for differentiating between Inflammatory Bowel Disease (IBD) and functional gastrointestinal disorders. However, there are different thresholds for interpreting FC results. The National Institute for Health and Care Excellence (NICE) therefore proposed the role of an intermediate range for values with Turvill et al. suggesting a cut off of >100. At Chesterfield Royal Hospital, no such intermediate range has been determined. The purpose of this study was thus to analyse FC results and referral outcomes to