was sent to the GP to advise that engagement was unsuccessful.

Results Of the initial 1162 patients, 241 were assigned to adjacent ODNs, 19 were deceased. Local laboratory systems allowed us to censor 105 patients with negative RNA following initial positive antibody testing. We made contact with 562/797 (70%) of the remaining patients, of whom 100 (12.5%) patients attended for further investigation and were confirmed PCR negative, 149 (19%) reported successful therapy outside the ODN, 21 (3%) reported documented spontaneous clearance, 12 were antibody and PCR negative (1.5%) four of whom categorically denied ever receiving a prior test, and 18 (2%) declined re-engagement. 5.9% of the total cohort were diagnosed with active HCV requiring further treatment (8.4% of the 562 patients we successfully re-engaged). Sadly, one patient was diagnosed with advanced hepatocellular carcinoma as part of work up following re-engagement.

Discussion Initial anxiety about the potential burden of work from the Lookback exercise was unfounded, as many patients were already known to the team or had already received successful treatment. Each telephone contact enabled re-engagement and a discussion regarding new treatment options for those concerned about side effects from previous treatments. We have accounted for 70% of patients, there may be an opportunity to attempt re-engagement of the missing 225 patients at a future date. Some patients were concerned that they were contacted regarding previous investigations, though the majority were happy to have the opportunity to receive treatment if required. We were able to educate and re-engage 47 patients for treatment, with significant personal and population benefits.

P56 MORTALITY IN PATIENTS WITH WILSON’S DISEASE IN ENGLAND: A NATIONAL REGISTER-BASED STUDY

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Background Wilson Disease (WD) is a rare genetic disorder of copper metabolism. Without appropriate treatment it can progress to liver failure and death. The National Congenital Anomaly and Rare Disease Registration Service (NCARDRS), with support from the Wilson Disease Special Interest Group, has established registration of WD in England. We aim to provide a descriptive study of mortality, including multiple cause of death and transplant status, of those with WD.

Method Confirmed cases of WD were reported by 20 hospital trusts and registered with NCARDRS enabled by their legal permissions (CAG 10-02(d)/2015) to collect patient data without consent. Vital status of all cases were determined and linkage with Office of National Statistics (ONS) mortality data was undertaken to obtain death certificate data. Cases of E83.0 Disorders of copper metabolism, between 2008–2018, were extracted from ONS mortality data. Cause of death free text was manually searched to identify deaths that mentioned WD. All deaths were linked to Hospital Episode Statistics (HES) inpatient data to determine transplant status.

Results Death records were identified for 52 patients, 65% were male, with a mean age of 45.5 years (range 17–82). Complications related to cirrhosis or liver failure were assigned as the underlying cause of death (UCOD) in 44%. Hepatocellular carcinoma (HCC) was the UCOD in 5.8%. Of the 21% of patients who were recorded as having a liver transplant, transplant complications or graft failure were recorded as a cause of death in 8%. Sepsis was mentioned on the death certificate in 42% and recorded as the UCOD in 21%.

Conclusion The contribution of WD to mortality in England will be underestimated unless multiple cause of death analysis is undertaken. The number of deaths resulting from complications related to cirrhosis or liver failure suggests that there might be missed opportunity for liver grafting. HCC was the cause of death in 5.8% of cases suggesting the prevalence of HCC in WD may be higher than previously thought. This project demonstrates the utility of the NCARDRS for WD in England.

P57 PATIENTS WITH SEvere ALCOHOLIC HEpatitis (AAH) AND MULTOrGAN dysFUNCTION ADMitted TO THE INTENSIVE THerAPY UNIT (ITU) HAVE SIGNIFICANTLY WORSE OUTCOMES THAN PATIENTS WITH ACUTE ON CHRONIC LIVER DISEASE (ACLD)

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Introduction Current assumption in the published literature is that AAH is not dissimilar to other forms of ACLF; however, the clinical syndrome of AAH is unique, characterised by profound jaundice and immune dysfunction. Therefore, the outcomes of patients requiring organ support in this setting may differ from other forms of ACLD.

Aim To determine whether the clinical outcomes of AAH patients with multi-organ failure admitted to ITU differ from those with other forms of ACLD.

Method Single-centre retrospective study of consecutive patients admitted to ITU with AAH (AAH ITU) between 10/2014 and 07/2017. Two comparator cohorts were identified - patients with AAH hospitalised but not requiring ITU (non-ITU AAH); and patients with non-AAA ACLD admitted to ITU (non-AAH ITU). The diagnosis of severe AAH was made prospectively adhering to the STOPAH trial criteria, and confirmed retrospectively by two independent Hepatologists; 37% of AAH patients had the diagnosis confirmed histologically.

Results 62 patients were diagnosed with severe AAH during the study period – at the time of hospital admission the median bilirubin was 319μmol/l and 63% had a Glasgow Alcoholic Hepatitis Score ≥9. 21/62 patients were admitted to ITU. AAH ITU patients were more likely to have CLIF-C ACLF (100% vs 80%, p=0.017), but had a similar SOFA score (p=0.064) and total number of organ supports (2 vs 2, p=0.447) to non-AAH ITU patients (n=70).

The 90-day survival was 29% for the AAH ITU patients, compared with 90% and 60% for non-ITU AAH and non-AAH ITU patients, respectively (p<0.001).

Overall, 15% of AAH ITU and 56% of non-AAH ITU patients who received any organ support survived to hospital discharge. Of the AAH ITU patients with a CLIF-C ACLF grade of 3, 1 patient (8%) survived to discharge, compared with 8/23 (35%) non-AAH ITU patients. Of the AAH ITU patients who required 3 organ support (n=8), none survived.