factors for NAFLD were significant predictors of liver pathology. The phenomenon of methotrexate-related hepatotoxicity is likely to have been historically over-estimated. Our results suggest that this cohort had NAFLD as the underlying cause of liver fibrosis. The STRATIFY study continues to recruit participants.

REFERENCES


Introduction Ascites is a leading cause of hospital admission in patients with cirrhosis, with up to a third developing refractory ascites (RA). RA has a median transplant free survival of 10 months, 1 yet palliation remains sub-optimal and practice varies widely. Long term ascitic drains (LTAD) are standard of care in malignant ascites but there is a paucity of data to support use in advanced cirrhosis. Our aim was to establish current views and practices of gastroenterologists and hepatologists towards LTAD as a palliative intervention in advanced cirrhosis.

Methods An electronic survey of 10 questions was designed by a focus group of four hepatologists with a special interest in palliative management of advanced cirrhosis. The survey included seven questions with fixed quantitative options and three exploratory questions with free text space. The survey was logged on survey monkey and distributed electronically via the BASL website and also to relevant departments in Brighton and North East London, with reminder emails in four and eight weeks.

Results The survey was completed by 210 respondents over 16 weeks with 99% completion rates for all questions with quantitative endpoints. Respondents included Hepatologists (36.8%), specialist nurses (24.4%) gastroenterologists (16.3%) and trainees (15.3%). Ninety-six percent of respondents looked after patients with RA and 70% had experience of LTAD. All respondents had access to large volume paracentesis, 86.1% to TIPSS, 67% to LTAD and 6% to the Alpha pump. The commonest deterrent to use of LTAD was infection risk (90%), followed by community management of LTAD in these complex patients (56.5%). Patient/carer dissatisfaction (as reported by clinicians) did not seem to be a major cause of concern.

Fifty-six percent of those with experience reported clinical consequences (bleeding, infection, renal impairment) 41.4% reported technical issues and 35.8% inadequate community support. Additional themes emerged, including: lack of clear guidance on use of LTAD in advanced cirrhosis, the role of human albumin solution, monitoring of renal function and funding.

Conclusions This national survey of clinicians managing RA in the setting of advanced cirrhosis shows that the majority would be willing to consider LTAD, the main deterrent being infection risk. Additional concerns identified were: lack of training, funding concerns and absence of clear guidelines on community management of LTAD. Our survey highlights the need for a robustly designed randomised controlled trial to assess palliative interventions for the management of RA in advanced cirrhosis.

REFERENCE


P1 LONG TERM ABDOMINAL DRAIN FOR PALLIATION IN ADVANCE LIVER CIRRHOSIS: A SURVEY OF RISKS & BARRIERS

Jane Abbott*, 2,3 Sumita Verma, 4 Sushma Saksena. 1University College Hospital, London, UK; 2Department of Gastroenterology and Hepatology, Brighton and Sussex University Hospitals, UK; 3Department of Clinical and Experimental Medicine, Brighton and Sussex Medical School, UK; 4Royal London Hospital, London, UK

Introduction Ascites is a leading cause of hospital admission in patients with cirrhosis, with up to a third developing refractory ascites (RA). RA has a median transplant free survival of 10 months, yet palliation remains sub-optimal and practice varies widely. Long term ascitic drains (LTAD) are standard of care in malignant ascites but there is a paucity of data to support use in advanced cirrhosis. Our aim was to establish current views and practices of gastroenterologists and hepatologists towards LTAD as a palliative intervention in advanced cirrhosis.

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involved in mechano-transduction. PDLIM5 mRNA expression was confirmed by qPCR, and PDLIM5 protein expression was demonstrated by WB and ICC in both LX-2 cells and primary HSCs. Stimulation of LX-2 cells with TGFβ (2 ng/ml) for 24 hrs significantly increased expression of enigma proteins. siRNA knock down of PDLIM5 reduced the expression of fibrogenic genes including ACTA2, CTGF, and COL1; and was accompanied by increased cytoplasmic localization and phosphorylation (inactivation) of YAP1.

Conclusion In brief, our work defined a new mechanism for activation and nuclear translocation of YAP1 in HSCs via the enigma family protein PDLIM5. Understanding hippo independent mechanisms of YAP1 activation in HSCs may reveal novel targets for urgently needed anti-fibrotics.

**P3 PORTO-MESENTERIC THROMBOSIS IN A NON-CIRRHTIC PATIENT WITH SARS-COV-2 INFECTION**

Kushala Abeysekera*, Jane Gitahi, Richard Flood, Alexis Sudlov, Stephen Lyen, Amanda Clark, Fiona Gordon. Department of Liver Medicine, Bristol Royal Infirmary, University Hospitals Bristol NHS Foundation Trust, Bristol, UK; 2Department of Radiology, Southmead Hospital, North Bristol NHS Foundation Trust, Bristol, UK; 3Department of Surgery, Southmead Hospital, North Bristol NHS Foundation Trust, Bristol, UK; 4Department of Radiology, Bristol Royal Infirmary, University Hospitals Bristol and Weston NHS Foundation Trust, Bristol, UK; 5Bristol Haematology and Oncology Centre, University Hospitals Bristol and Weston NHS Foundation Trust, Bristol, UK

**Introduction** During the coronavirus 2019 (COVID-19) pandemic, it is clear this novel coronavirus generates a markedly hypercoagulable state. Thrombotic events are driven by a severe pro-inflammatory response to COVID-19 as well as hypoxia manifested in severe illness. Whilst the commonest thrombotic events associated with COVID-19 remain pulmonary embolism, myocardial infarction and deep vein thrombosis, intra-abdominal thromboses are less well characterised, but are illustrated in this case.

**Case Presentation** A 42 year-old Eastern European man with chronic hepatitis B (undetectable viral load on Entecavir; eAg negative; sAg positive; alanine transaminase (ALT) 34 IU/l; FibroScan 7.4kPa Nov 2019), and prior trauma-related splenectomy, non-radiating right hypochondrial pain. The following day he was commenced on Amoxicillin, then Doxycycline, for presumed bronchitis (no imaging). His bilirubin was 4.44 mol/l, ALT 55 IU/l, alkaline phosphatase (ALP) 66 IU/l and albumin 35 g/l. Abdominal ultrasound of the kidneys and liver was normal. A CT-abdomen demonstrated loss of enhancement of the portal vein along with collateralisation extending into the upper abdomen. There has been an increase in TIPSS procedures from 2017–2020; 69 (Suppl 1):A1

**Discussion** This is one of the first cases of likely COVID-19-related porto-mesenteric thrombosis to be described in the UK. Similar cases have been described in France and Italy in non-cirrhotic patients. With almost a fifth of COVID-19 infections presenting with gastrointestinal symptoms, and a recent meta-analysis suggesting 9.2% developing abdominal pain, our threshold for performing liver ultrasound with doppler assessment must be lower to avoid missing this reversible complication of COVID-19.