Conclusion This study shows operator feedback can dramatically increase LB adequacy. Single pass predicts sub-standard yield. In our study, switching from 18G to 16G calibre was not associated with significant increase in PT yield but did correlate with mild/moderate pain. CL ≥20 mm appears to be an accurate predictor of PT yield meeting the audit standard. Regular auditing and feedback can be an important tool to drive up the quality and yield of LB.

REFERENCES

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P380 INPATIENTS WITH ADVANCED ALCOHOL-RELATED LIVER DISEASE ARE NOT BEING CONSIDERED FOR TRANSPLANTATION: A REGIONAL AUDIT

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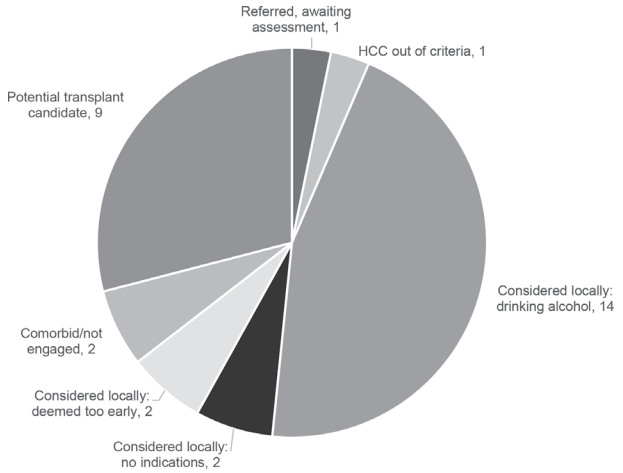
Introduction Alcohol-related liver disease (ArLD) remains a leading cause of premature mortality in the UK. In 2018/9 there were over 330,000 alcohol-specific hospital admissions and 5600 deaths. Although many of these patients have advanced disease and multiple admissions, there is a lack of data around access to liver transplantation.

Method A spot audit of all inpatients with ArLD was performed in 9 hospitals in the South West on a single day in February 2020. Anonymised data was collected using a standardised collection form on patient characteristics and documentation of consideration for transplantation.

Result 9 hospitals provided data: 1 tertiary, 2 large acute trusts and 6 district generals. 31 inpatients (20 [65%] male; median age 62 years [IQR 50–70]) were included. None were liver transplant recipients. 11 patients (35%) had alcoholic hepatitis. 90% had decompensation of ArLD: 84% had ascites (15% treated for SBP), 39% hepatic encephalopathy and 13% upper GI bleeding. Median UKELD was 58 (IQR 55–62) and MELD 21.5 (IQR 19–25). 56% had Child Pugh C and 39% Child Pugh B severity.

55% of patients were drinking alcohol at admission. 48% were known to alcohol services. Where data were available (14 cases) median intake of alcohol was 63 units/week (IQR 32–96). In the abstinent group, median duration of abstinence was 6 months (IQR 1.6–12).

Only 2 patients (6%) had documentation in the notes of being considered for transplantation (both deemed 'too early'). 1 patient had been referred for assessment at a transplant unit. There was no documentation in patient records in the remaining 28 patients (90%). In this group, eligibility for transplantation was considered. 19 patients were deemed illegible. Data were not available for 9 patients (figure 1).



Abstract P380 Figure 1 Consideration for transplantation

Conclusion This regional spot audit demonstrates that inpatients with ArLD have advanced disease and suggests that this group is not routinely being considered for liver transplantation. We acknowledge that our data are limited by availability and accuracy of documentation in patient records. Although a small sample size, this represents inpatients in a variety of hospital settings across the whole of the South West. We aim to use this as a pilot for a national audit to evaluate access of ArLD patients to liver transplantation.

P381 DEFINING HCV CIRRHOSIS BY FIBROSCAN SCORE HAS A SIGNIFICANT IMPACT ON HCC SURVEILLANCE BURDEN

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Introduction Patients with hepatitis C (HCV) related cirrhosis should undergo 6 monthly hepatocellular carcinoma (HCC) surveillance, as this has been shown to be effective in increasing longevity where the incidence of HCC is greater than 1.5% per year.[1] NHS England define HCV cirrhosis on Fibroscan®/transient elastography (TE) as a liver stiffness measure (LSM) >11.5 kPa[2] prior to commencing direct-acting antiviral (DAA) treatment. AASLD guidelines define HCV cirrhosis as a LSM score of >12.5 kPa, and >14 kPa has been used in other studies.[3] This lower score by NHS England may lead to a higher burden of HCC surveillance in HCV patients. This study aimed to assess the impact of HCC risk if higher LSM measurements are used to define cirrhosis, and to evaluate the impact on the subsequent ultrasound (US) surveillance burden.

Methods 100 patients with HCV with a LSM >11.5 kPa on TE using the local treatment database were identified, and from this 53 patients had a complete set of data at the time of the pre-DAA treatment Fibroscan® allowing a 3 year HCC percentage risk to be calculated using the validated HCC calculator.[4] The cirrhosis parameter within the risk score calculator was defined as a Fibroscan® score of either >11.5 kPa, >12.5 kPa, or >14 kPa, and comparisons were made of HCC risk between HCV cirrhosis and non-cirrhosis patients depending on LSM cut off for cirrhosis in each of these groups. Statistical significance between cirrhotic and non-cirrhotic HCC risk was performed using a Mann-Whitney test, and reduction in US surveillance burden was calculated as a percentage.

Results When HCV cirrhosis was defined as a LSM of >12.5 kPa, the 3 year risk of HCC was 2.91% compared to non-cirrhosis patients (LSM ≤12.5 kPa) who had a risk of 0.15% (p = <0.0001). HCV cirrhosis defined as a LSM score of >14