endoscopy report. We analysed the data by using One-Way ANOVA on SPSS.

Results Total number of hepatology admissions during the study period was 183 patients with 65% (n=119) known to have liver cirrhosis. 74% were male (n=137) of total admissions and only forty-six female patients. Among individuals with liver cirrhosis, twenty-seven patients had Child-Pugh (A) liver cirrhosis with Fifty and forty-two had Child-Pugh (B) and (C) respectively. Admission with decompensated Alcoholic liver Cirrhosis was higher in male patients 69% (n=47) compare to female patients of only 30% (n=21) (p= 0.001). None of the patients had autoimmune or metabolic liver disease as main cause of cirrhosis (p= 0.0001). Oesophageal varices were diagnosed in thirty-one patients (26%) predominantly males (n=22). HCC surveillance with Ultrasound occurred in 85% (n=102) whereas only 73 patients (61.3%) had AFP checked. The ANOVA results suggest the HCC surveillance differs significantly between different stages of liver cirrhosis (Child-Pugh A, B and C) (F3,359 = 6.11, p= 0.003). Male patients had more robust HCC surveillance (M=37.61, SD=23.46, n=13) in comparison to Female patients with liver cirrhosis (M=13.38, SD = 8.60, n = 13). This was statistically significant, t (24) = 2.06, (p= 0.0009).

Conclusion More than two third of Hepatology admissions have liver cirrhosis, however, the study period was during the first COVID-19 wave, yet the adherence to the BSG in HCC surveillance guidelines was achieved in 85% and 61.3% with USS and AFP respectively. Significant improvement is required; hence, we recommend adding checklist and proforma to the patients' record as this may improve our practice.

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P009

BIOLOGIC INDUCED HEPATOTOXICITY IN INFLAMMATORY BOWEL DISEASE (IBD); A SYSTEMATIC REVIEW AND META-ANALYSIS

¹Eyad Gadour*, ²Zeinab Hassan. ¹University Hospitals of Morecambe Bay NHS Foundation Trust, UK; ²Stockport Hospitals NHS Foundation Trust, UK

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Introduction Hepatotoxicity and use of biologic drugs have historically been challenging in IBD.¹ We aim to study the prevalence of hepatotoxicity in adult patients using biologic medications.

Methodology With the guidelines described by PRISMA-P, a detailed search strategy for each electronic database were developed based on the one used for PubMed, Medline, and Embase. We include prospective and retrospective RCTs that assessed the efficacy and hepatotoxicity of biologics in IBD patients. Hepatotoxicity was defined as AST and/or ALT >2x upper limit of normal or cholestasis. We used Review Manager 5 (RevMan5) to analyse the data. We calculated the Odds ratio (OR) with a 95% confidence interval (CI). We assessed heterogeneity using the chi2 test and the I2 statistic.

Results We identified 862 records in total. After we had removed duplicates 564 records were left for review. Four

studies did not report on how participants were randomized to treatment groups or how allocation concealment was achieved, we rated these studies at unclear risk of bias for these domains.² All our included trials mentioned adverse effect of biologics on liver which are analysed statistically, and result is summarized in figure 1. They were no presence of any heterogeneity among studies by (Chi2= 2.21, df = 6, P = 0.90, and I2= 0%), when the whole seven studies were involved for analysis. Our meta-analysis was conducted on the fixed effects model, with the (0.770, 95% CI [-0.630, 0.957], and P = 0.02). Hepatotoxicity was not related to any TNF-α antagonist. Thiopurine induced liver injury occurred more frequently within the first months of treatment, 50% of cases within the first 3 months. Although, risk of hepatotoxicity above the third quartile (6-MMPR > 5,300) was 5 times that below the third quartile (11.4%vs 2.3%, P < 0.05).

Conclusion When hepatotoxicity occurred, the treatment was withdrawn in thirty one percent of patients, but an important percentage, forty-four was able to continue full dose of thiopurine once the dose was temporarily adjusted. This group of patients had a dose-dependent hepatotoxicity rather than an immunologic hepatitis.

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P010

END OF LIFE CARE IN PATIENTS WITH CIRRHOSIS: A DISTRICT GENERAL HOSPITAL PERSPECTIVE

Emma Saunbury*, Daniel Maggs. Royal United Hospitals NHS Foundation Trust, Bath, UK

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End of life care (EOLC) refers to care given to patients with a prognosis of less than one year. Whilst cirrhosis-related death can be unforeseen, it typically concludes a prolonged declining clinical trajectory. Clinical encounters represent key opportunities for EOLC planning in this cohort, yet the limitations of current provision by gastroenterologists are increasingly recognised.¹ We reviewed our practice to identify areas for improvement.

This retrospective cohort study identified patients who died from sequelae of cirrhosis between 1st January 2018–31st December 2019 and had at least one non-terminal cirrhosis-related admission in their last year of life. Electronic records were interrogated for evidence of prognostication assessment, transplant candidacy and gastroenterology input. Discussions regarding end-stage liver disease (ESLD), EOLC and palliative care referral were reviewed.

52 patients were identified for analysis. In their last year of life, patients averaged 1.7 cirrhosis-related admissions and 69.2% had at least one outpatient clinic. 61.5% had no prognostication score documented, including 58.3% (7/12) of Child-Pugh C patients. Interestingly, only 23.6% met >2 poor-prognosis criteria prior to their terminal admission.¹

ESLD was discussed in a quarter of patients in advance of terminal admission, yet EOLC was subsequently broached in only 61.5% (8/13) of these cases. Just 33.3% of Child-Pugh