TREATMENT OF PRIMARY BILIARY CHOLANGITIS (PBC): RETROSPECTIVE REVIEW OF CURRENT THERAPIES IN A DISTRICT GENERAL HOSPITAL

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Introduction We retrospectively reviewed current therapies of patients with Primary Biliary Cholangitis (PBC) at Mid Yorkshire Hospitals NHS Trust (MYHT). MYHT provides hospital services to a population of 500,000.

Methods We undertook a retrospective review of 542 patient records and clinic letters. Information was obtained from electronic patient records and Sunquest ICE system. We included patients who were under outpatient review in both the Hepatology and Gastroenterology services; over a 3 year period from December 2017 to December 2020.

Results 87% (n= 34) of the patient were on ursodeoxycholic acid (UDCA) therapy. Among the patients who were not on UDCA therapy, 75% (n=3) was due to their liver function test being normal and therefore they were undergoing annual monitoring and 25% (n=1) were due to medication side effects (e.g. diarrhoea).

Of the patients on UDCA therapy, 56% (n=19) were on a therapeutic dose (13–15mg/kg/day). 79% (n=27) had achieved a good clinical response; biochemical normalisation in liver function tests (LFTs) with UDCA therapy with the remainder having a suboptimal biochemical response. No patient had been started on Obeticholic acid (OCA); however, 50% (n=4) of patients who have failed or intolerant to UDCA therapy were being considered for OCA therapy. Our audit showed that all patients with diagnosed PBC and abnormal LFTs had been offered and started on UDCA therapy. No patients were on fibrate therapy.

Discussions The standard recommended by the British Society of Gastroenterologists (BSG) is that 90% of patients receive a therapeutic dose of UDCA and documented if intolerant. Therefore, there is still room for improvement in our current practice. It is also essential to ensure diagnosed patients be started on UDCA therapy earlier and to be referred early for OCA therapy if they fail UDCA therapy. Beazafibrate or fibrate therapy should be considered as add-on therapy for patients with incomplete response or intolerance to UDCA therapy.1 2

REFERENCES

Abstract P014 Table 1

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<th>Number of patients (n=39)</th>
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<td>UDCA therapy</td>
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Abstract P015

Patient name: Hospital No: 
DOB: NHS No: 
Age: Gender: Male/ Female 

Date of Clinic: 
Weight: Height: 
BMI: Alcohol use (unit): 

**PBC Diagnostic Criteria**

Date Of Diagnosis: 
AMA: Y/N 
ANA: Y/N 
Liver biopsy: Y/N 
Fibroscan: Date: 

**Bloods:**

Date: 
Hb: Pts: Clotting: 
ALT: AST: ALP: Bil: Albumin: 
Sodium: Creatinine: 
Glucose: Lipid: HBA1C 

**Comorbidities**

Dyslipidaemia: Y/N 
Hypertension: Y/N 
Diabetes: Y/N 
Cirrhosis: Y/N 
Others: 

QOL score (PBC –40 questionnaire): 
Itch score (0-10): 

**Treatment**

Cholestyramine: Y/N 
Rifaximin: Y/N 
Ursodeoxycholic acid: Y/N Dose: 
Obeticholic acid: Y/N Dose: 
Fibrates: Y/N Dose: 
PBC trial: Y/N 

**Cirrhosis surveillance patients,**

DGD: Y/N Result: 
Next Due: 

Liver USS: Y/N Result: 
Next Due: 

Dexa Scan: Y/N Result: 
Next due: 

Abstract P015 Figure 1
Background and Aims Splanchnic vein thrombosis can lead to portal hypertension and/or bowel ischaemia with potential infarction. These complications are not always prevented by anticoagulation (Low Molecular Weight Heparins (LMWH) or oral anticoagulants). In December 2019, Royal Free Hospital (RFH) developed a guideline for use of low dose tissue plasminogen activator (Alteplase) thrombolysis (l-tPAT) for splanchnic vein thrombosis. This therapy has been used in the treatment of 40 patients between 2014 and 2019 with variable success. The aim of this audit was to investigate if patients are appropriately initiated and monitored on l-tPAT in line with the guideline, clinical and radiological outcomes, and the impact of specialist pharmacist interventions.

Method All patients initiated on l-tPAT for splanchnic vein thrombosis from December 2019 to March 2021 at RFH were investigated. Data from electronic dispensing records, patient notes, prescriptions, and discharge letters were used to determine if patients met initiation criteria, investigate changes made to l-tPAT, response to therapy, patient outcomes and pharmacist interventions.

Results A total of 25 patients received l-tPAT. The mean age was 48 years with a Male:Female ratio of 14:11. 100% of patients met initiation criteria. Treatment was interrupted due to low fibrinogen in 46%(11) and adverse effects (AE) recorded in 29%(7), 8%(2) stopped due to AE with 4%(1) suffering a serious AE. Overall, 58%(14) of patients had therapy interrupted and/or stopped due to blood test abnormalities and/or adverse effects. Figure 1 shows outcomes following imaging review. 56%(14) had identifiable risk factors for thrombosis. Small bowel resection was eventually required in 3 patients. A total of 104 pharmacy interventions were recorded for 20 patients, the majority on appropriate initiation (28%), prescribing (27%) and monitoring (13%).

Conclusion Initiation of l-tPAT was appropriate in all patients. Due to the majority of patients experiencing a decrease in fibrinogen and/or AE, this therapy requires close biochemical and patient monitoring. Specialist pharmacist input is key in ensuring appropriate initiation, prescribing and monitoring and hence, patient safety when on high-risk therapy. Patient outcomes at first review showed that 46% of patients showed no recanalisation of their clot burden with 29% requiring Transjugular intrahepatic portosystemic shunt (TIPSS) ± Catheter Directed Thrombolysis (CDT) and 13% small bowel resection. A larger sample size with evaluation of long-term patient outcomes is required to establish the overall effectiveness of l-tPAT.