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P014

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 530,000.

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 tolerant. 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. Bezafibrate or fibrate therapy should be considered as add-on therapy for

patients with incomplete response or intolerance to UDCA therapy.^{1 2}

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P015

RETROSPECTIVE ANALYSIS OF FOLLOW UP IN PRIMARY BILIARY CHOLANGITIS (PBC) IN A DISTRICT GENERAL HOSPITAL

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Introduction We performed a retrospective audit on improvement needed for follow up among patients with Primary Biliary Cholangitis (PBC) at Mid Yorkshire Hospitals NHS Trust (MYHT) from the perspective of symptom, treatment and follow up in comparison with the recommendation from British Society of Gastroenterology.

Methods Retrospective analysis of patient records and clinic letters. We included patients who are currently having follow up with the Hepatology and or Gastroenterology services and reviewed their medical records for the past 3 years. We will be summarising the improvement needed in follow up to achieve the standards recommended by the British Society of Gastroenterology.

Results With regards to the symptom management, 28% (n=11) complained of itching, but only 4% (n=2) of the 28% have been prescribed first-line agents such as cholestyramine and 28% (n=11) of them has complained of fatigue as a symptom. This was usually attributed to being multifactorial but there was no structured approach in quantifying fatigue and its impact.

In terms of therapy, there was clear documentation on whether Ursodeoxycholic Acid has been started and the reason if it was not or it has been stopped. However, only 56% (n=19) were on the therapeutic dose.

46% (n=18) have not had an up to date bone density scan (DEXA scan) and the reason was not documented in the clinic letter.

The standards recommended by the British Society of Gastroenterology (BSG) involve 90% have the presence/absence of symptoms recorded in the notes and have suggested tools to quantify symptom such as tiredness.¹ It is also recommended that 90% of patients receiving therapy at adequate dose.¹

Discussions All the patient with diagnosed PBC and deranged liver function tests had been offered UDCA therapy and clear documentation when they were not. Improvement is still needed to ensure that patient is on the therapeutic dose of UDCA therapy. Documentation of symptom needed in each review to assess the impact of the disease on quality of life using multi-domain PBC-40 QOL measure¹. To achieve the goals set out by BSG, we have designed and implemented a clinical proforma to be used during clinical follow up with patients. We intend to perform a re-audit in a year time to ensure improvement in care for patients with PBC.

Abstract P014 Table 1

	Number of patients (n=39)
UDCA therapy	
Ongoing	34
Not on treatment	5
Dosage of UDCA therapy	
Therapeutic	19
Subtherapeutic	15

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:	Plts:	Clotting:		
ALT:	AST:	ALP:	Bili:	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
Rifampicin: Y/N
Ursodeoxycholic acid: Y/N Dose:
Obeticholic acid: Y/N Dose:
Fibrates: Y/N Dose:
PBC trial: Y/N

Cirrhosis surveillance patients,

OGD: Y/N Result:
Next Due:

Liver USS: Y/N Result:
Next Due:

Dexa Scan: Y/N Result:
Next due:

Abstract P015 Figure 1

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P016

AUDIT ASSESSING INITIATION, MONITORING, OUTCOMES AND IMPACT OF SPECIALIST PHARMACIST INTERVENTIONS ON THE USE OF LOW DOSE TISSUE PLASMINOGEN ACTIVATOR (ALTEPLASE) THROMBOLYSIS FOR SPLANCHNIC VEIN THROMBOSIS

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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%).

Abstract P016 Figure 1

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.

P017

IMMUNOTHERAPY RELATED HEPATOTOXICITY: A RETROSPECTIVE, DESCRIPTIVE ANALYSIS OF PATIENTS TREATED WITH COMBINATION IMMUNOTHERAPY AT A SINGLE CENTRE

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Immune checkpoint inhibitors have transformed the treatment of various cancers including metastatic melanoma. Immune checkpoints are regulatory mechanisms which modulate the immune system and prevent overwhelming autoimmune attack. This may be exploited by certain tumour types, leading to attenuation of T cell activation and thus expansion and growth of tumour cells. Blockade of pathways including CTLA-4, PD-1 and PDL-1 has emerged as an approach to remove this inhibitory immune checkpoint mechanism and allow host to mount immune responses against tumour cells.^{1 2}

Immune related adverse events (irAEs) are important, as high grade toxicities may require corticosteroids and discontinuation of treatment. The incidence of high grade irAEs is greater with CTLA-4 inhibitors (ipilimumab) than PD-1 inhibitors (nivolumab), and risk is increased further in combination (Ipi/Nivo). Ipi/Nivo induced hepatitis is an important irAE occurring in 17.6% patients (any grade) with 8.3% experiencing grade 3/4 hepatitis, based on previous trial data.³⁻⁶

Abstract P017 Figure 1 Treatment with corticosteroids amongst patients with any grade of hepatotoxicity. In addition, 4 patients (11.1% of all patients with any grade hepatotoxicity) required addition of mycophenolate mofetil (MMF) due to suboptimal response to steroids. One patient also required addition of tacrolimus. Other agents used for different irAEs included infliximab and sulfasalazine.