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.

Abstract P016 Figure 1

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

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Continued analysis of real-world data is important to better establish the natural history of immunotherapy related hepati-
tis. Lancashire Teaching Hospitals is the tertiary cancer centre for Lancashire and South Cumbria. Electronic records, bio-
chemistry results and oncology prescribing databases were retro-
spectively analysed for 68 patients treated with Ipi/Nivo be-
tween August 2016 and October 2020.

36 (52.9%) patients experienced hepatotoxicity (any grade) with n= 11 (16.2%) patients developing grade 3 or 4 hepati-
tis. The median time of onset of hepatotoxicity from the first
dose (all grades) was 40 days (range 8–322).

Amongst patients who experienced hepatotoxicity, the propor-
tion treated with intravenous, oral or nil corticosteroids was 47.2%, 38.9% and 13.9% respectively. 4 patients required
escalation to MMF and 1 patient needed tacrolimus as a third
agent. Of patients who developed hepatotoxicity, n=29 had combination treatment discontinued prior to completion of 4
cycles. 15 patients were re-challenged with single agent nivolu-
mab. Of the patients re-challenged, n=9 (60%) did not expe-
rience any further hepatotoxicity.

This data demonstrated Ipi/nivo induced hepatitis occurring
at a higher rate than in reported studies. This highlights the
importance in monitoring real world data with novel anti-can-
cer therapies however, larger collaborative datasets are
required. In addition, further comparative effectiveness
research regarding treatment with oral vs intravenous cortico-
steroids will be important. The latter usually requires hospital
admission, which has cost, service and patient experience

Abstract P017 Figure 2

Abstract P017 Figure 3
implications. Finally, further analysis of phenotypic and biochemical variables associated with hepatotoxicity may identify important trends to allow better prediction and thus appropriate counselling and informed discussion when planning treatment.

REFERENCES

Abstract P017 Table 1

<table>
<thead>
<tr>
<th>Hepatotoxicity (Any grade)</th>
<th>Male n (%)</th>
<th>Female n (%)</th>
<th>Mean and (median) age</th>
<th>Median number of cycles prior to onset of toxicity n</th>
<th>Median time from first dose to onset of hepatotoxicity</th>
<th>Median time for resolution of hepatotoxicity *</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=21</td>
<td>21 (48.9%)</td>
<td>15 (60%)</td>
<td>53.5 years (55)</td>
<td>2</td>
<td>40 days (range 8–322)</td>
<td>n/a</td>
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<tr>
<td>N=15</td>
<td>15 (60%)</td>
<td>6 (24%)</td>
<td>53.6 (57)</td>
<td>1</td>
<td>27 days</td>
<td>27.5 days (range 5–154)</td>
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<tr>
<td>N=53</td>
<td>53 (75.7%)</td>
<td>4 (6%)</td>
<td>57.2 years (58)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*Defined as the point at which ALT < 3 times upper limit of normal

Abstract P018 Table 1

<table>
<thead>
<tr>
<th>N=99</th>
<th>Drinking recipients (n=22)</th>
<th>Non-drinking recipients (n=77)</th>
<th>pValue</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=77</td>
<td>16 (72.7)</td>
<td>54 (70.1)</td>
<td>0.813</td>
</tr>
<tr>
<td>Age, mean (SD, years)</td>
<td>53±12</td>
<td>59±10</td>
<td>0.020</td>
</tr>
<tr>
<td>Male sex, n (%)</td>
<td>16 (72.7)</td>
<td>54 (70.1)</td>
<td>0.813</td>
</tr>
<tr>
<td>ALD-related LT, n (%)</td>
<td>6 (27.3)</td>
<td>54 (29.9)</td>
<td>0.018</td>
</tr>
<tr>
<td>Married, n (%)</td>
<td>16 (72.7)</td>
<td>54 (70.1)</td>
<td>0.005</td>
</tr>
<tr>
<td>Working, n (%)</td>
<td>10 (45.5)</td>
<td>43 (55.8)</td>
<td>0.018</td>
</tr>
<tr>
<td>Active smoking, n (%)</td>
<td>7 (31.8)</td>
<td>43 (55.8)</td>
<td>0.037</td>
</tr>
<tr>
<td>Household alcohol consumption, n (%)</td>
<td>9 (40.9)</td>
<td>24 (29.7)</td>
<td>0.136</td>
</tr>
</tbody>
</table>

Abstract P018

ALCOHOL CONSUMPTION POST-LIVER TRANSPLANTATION AT A PORTUGUESE CENTER: A CROSS-SECTIONAL STUDY

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Background Alcohol-associated liver disease (ALD) is one of the leading causes of liver transplantation (LT). However, LT listing in ALD remains challenging regarding the risk of alcohol relapse post-LT. We aimed to evaluate post-LT alcohol consumption at a Portuguese transplant center.

Methods We conducted a cross-sectional study including LT recipients transplanted in 2019 at Curry Cabral Hospital, Lisbon, Portugal. A pre-tested survey including questions on demographic, family, employment and social status, and a validated Portuguese translation of the Alcohol Use Disorder Identification Test (AUDIT) was applied via telephone call. Alcohol consumption was defined by patients’ self-report or a positive AUDIT. Informed consent was conveyed by accepting to respond the survey. No donor organs were obtained from executed prisoners or other institutionalized persons.

Results In 2019, 122 patients underwent LT at Curry Cabral Hospital. At interview date (June 2021), 19 recipients had died, 2 were being followed abroad, 2 did not consent and 99 answered the survey. Among responders mean±SD age was 57±10-year-old, 70 (70.7%) were males, and 49 (49.5%) underwent ALD-related LT. During a median (IQR) follow-up of 24 (20–26) months post index LT, 22 recipients (22.2%) consumed alcohol: 14 had a drink once a month or less and 8 drank 1–4 times/month. On drinking days, 18 consumed 1–2 drinks and the remainder no more than 3–4 drinks. Only one patient reported to have drunk ≥6 drinks on one occasion. All post-LT drinking recipients were considered low-risk (score <7) as per AUDIT score (median 1 (1–2)). No patient reported alcohol-related problems, whether self or towards others.

Among drinking LT recipients, non-ALD-related LT (72.7%) vs 44.2%, p=0.018, active smoking (31.8% vs 10.4%, p=0.037) and younger age (53±12 vs 59±10-year-old,

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