Abstract P017 Table 1 Summary of patient characteristics, onset and resolution of hepatotoxicity

	Male n (%)	Female n (%)	Mean and (median) age	Median number of cycles prior to onset of toxicity n	Median time from first dose to onset of hepatotoxicity	Median time for resolution of hepatotoxicity*
Hepatotoxicity (Any grade)	21 (48.9%)	15 (60%)	53.5 years (55)	2	40 days (range 8–322)	n/a
Hepatotoxicity (Grade 3 or 4)	5 (11.6%)	6 (24%)	53.6 (57)	1	27 days	27.5 days (range 5–154)
No Hepatotoxicity	17 (39.5%)	4 (16%)	57.2 years (58)	n/a	n/a	n/a

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

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.

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P018 ALCOHOL CONSUMPTION POST-LIVER TRANSPLANTATION AT A PORTUGUESE CENTER: A CROSS-SECTIONAL STUDY

¹Carolina Chálim Rebelo, ²Catarina Félix*, ³Filipe Cardoso, ³Luís Bagulho, ³Mónica Sousa, ³Milena Mendes, ³Helena Glória, ³Élia Mateus, ³Hugo Pinto Marques, ³Fernando Nolasco, ³Américo Martins, ³Rui Perdigoto. ¹Hospital Do Divino Espírito Santo De Ponta Delgada, Ponta Delgada, Portugal; ²Centro Hospitalar de Lisboa Ocidental, Lisbon, Portugal; ³Hospital Curry Cabral, Lisbon, Portugal

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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 demography, 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,

Abstract P018 Table 1

N=99	Drinking recipients (n=22)	Non-drinking recipients (n=77)	pValue
Male sex, n (%)	16 (72.7)	54 (70.1)	0.813
Age, mean (SD), years	53±12	59±10	0.020
ALD-related LT, n (%)	6 (27.3)	43 (55.8)	0.018
Married, n (%)	16 (72.7)	55 (71.4)	0.905
Working, n (%)	10 (45.5)	24 (31.2)	0.213
Active smoking, n (%)	7 (31.8)	8 (10.4)	0.037
Housemate alcohol consumption, n (%)	9 (40.9)	19 (24.7)	0.136

$p=0.02$) were significantly more prevalent than in abstinent LT recipients (table 1).

Conclusion At our center, almost $\frac{1}{4}$ of recipients consumed alcohol early on post-LT, all with a low-risk pattern according to AUDIT score. Interestingly, alcohol consumption was more prevalent in non-ALD-related LT.

P019 LIVER SIZE AND HEPATIC FAT INDICATE DIFFERING PHENOTYPES OF ACUTE ALCOHOLIC HEPATITIS

¹Nawaz Safdar*, ¹Adam Tahir, ²Richard Parker. ¹University of Leeds, Leeds, UK; ²St James's University Hospital, Leeds, UK

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Introduction Alcoholic hepatitis (AH) is an acute manifestation of alcohol related liver disease with very poor survival. The aim of this study was to identify phenotypes of AH based on radiological measures of liver size and hepatic fat content.

Methods Consecutive patients admitted to our institution with a clinical diagnosis of AH (based on the NIAAA definition) who had computed tomography (CT) imaging of the abdomen within 10 days of admission were included. AH phenotypes were defined by two parameters: a. hepatic steatosis was calculated using a liver/spleen attenuation ratio (LSR) of 1.0 as the cut-off, and b. liver volume characterised as small if $<2000 \text{ cm}^3$ and large if $>2500 \text{ cm}^3$. Hepatic VCAR was used to obtain both LSR and liver volumes. STATA 16 was used for statistical analyses. Kaplan Meier analysis was used to describe survival from admission and the log-rank test was used to compare survival between groups. Medians were used to describe biochemical data.

Results 47 patients were included, out of which 56.7% were male. The median patient age was 48 (range 25–76). Liver volumes varied considerably in this cohort (median 2589 cm^3 , range 1016 cm^3 - 6352 cm^3). Patients were categorised as follows: Large Fatty (LF; $n=22$), Large Non-Fatty (LNF; $n=4$), Small Fatty (SF; $n=15$) and Small Non-Fatty (SNF; $n=6$). Overall median survival was 427

Abstract P019 Figure 1

days from admission. Survival was better in fatty livers compared to non-fatty livers ($P=0.01$, figure 1). These four groups differed with regard to median bilirubin and urea concentrations, which were both higher in patients with non-fatty livers (LF: bilirubin= $174.5 \mu\text{mol/L}$, urea= 3.25 mmol/L ; SF: bilirubin= $74.5 \mu\text{mol/L}$, urea= 3.4 mmol/L ; LNF: bilirubin= $250.5 \mu\text{mol/L}$, urea= 11.9 mmol/L ; SNF: bilirubin= $245.5 \mu\text{mol/L}$, urea= 7.1 mmol/L). Only 3 patients were treated with corticosteroids, insufficient for analysis of treatment response.

Conclusion Liver volume varies significantly between patients admitted to hospital with acute AH. Patients with fatty livers have better medium-term survival and both lower bilirubin and urea levels than people with non-fatty livers.

P020 IMPROVING CARE FOR PATIENTS WITH DELIRIUM TREMENS

Clare Phillips*. University Hospital Southampton NHS Foundation Trust, Southampton, UK

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Assess (the situation) From the start of 2021, as the UK entered another COVID19 lockdown, we noticed a stark increase in the numbers of patients presenting with, or developing, Delirium Tremens (DTs). While historically, it had been rare to see DTs within our organisation, it became a frequent occurrence and concerns were raised about staff safety and adverse outcomes for patients.

Diagnose (identify the problem) We (Alcohol Care Team) identified a knowledge gap in the recognition, treatment and nursing management of acute alcohol withdrawal amongst ward staff which was contributing to the onwads progression of DTs in patients.

Plan Using our Trust guidelines for alcohol withdrawal and team expertise, we developed a nursing care plan for patients experiencing acute alcohol withdrawal, outlining optimal care and highlighting key elements of the Trust policy.

Implement (deliver the plan) We used the care plan as a framework to guide informal teaching to staff on the Gastro/Hepatology wards. Furthermore, we made ourselves increasingly available when patients were in DTs and prioritised supporting staff in the hands on/active management of patients in DTs (akin to a low dose, high frequency approach, Jhpiego 2016)¹ in order to maintain safety, optimise patient care and demonstrate clinical leadership.

Evaluate (did the plan work? Where are we now?) The care plan has been well received by staff. It is due to be submitted through our internal governance structure in order for it to be used as a clinical tool in practice.

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