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

<table>
<thead>
<tr>
<th></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>Hepatotoxicity (Any grade)</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>
</tr>
<tr>
<td>Hepatotoxicity (Grade 3 or 4)</td>
<td>5 (11.6%)</td>
<td>6 (24%)</td>
<td>53.6 (57)</td>
<td>1</td>
<td>27 days</td>
<td>275 days (range 5–154)</td>
</tr>
<tr>
<td>No Hepatotoxicity</td>
<td>17 (39.5%)</td>
<td>4 (16%)</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

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

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 (I–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,
Abstracts

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

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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 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 cm³ and large if >2500cm³. 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 cm³, range 1016 cm³ - 6352 cm³). 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 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=174.5μmol/L, urea=3.25mmol/L; SF: bilirubin=74.5μmol/L, urea=3.4mmol/L; LNF: bilirubin=250.5μmol/L, urea=11.9mmol/L; SNF: bilirubin=245.5μmol/L, urea=7.1mmol/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 those with non-fatty livers.

Improving Care for Patients with Delirium Tremens

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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 onwards 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) 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.

REFERENCE


Acknowledgments With thanks to all members of the Alcohol Care Team who peer reviewed the care plan.