Methods From June 2018, a weekly Hepatology clinic was co-located with a primary care clinic serving a population of 2,500 PEH. Blood borne virus testing, near patient HCV RNA testing, transient elastography and anti-viral drug dispensing for Hepatitis B and C was introduced. All patients with HCV were treated in line with national guidelines.

Results Between the period of June 2018 and November 2020, 326 patients were reviewed within the Hepatology clinic. A total of 1,236 appointments were offered with 632 attendances (51.1%).

241 patients were referred due to a positive HCV Ab test. 193 were RNA positive (80%), 30 RNA negative (12.4%) and 19 had unknown HCV RNA status. Transient elastography was performed on 138 with 31 having advanced fibrosis.

Treatment was initiated on 101/193 HCV RNA positive patients. 93 patients were receiving opiate substitution therapy. 65% had a co-existing mental health diagnosis whilst 24% had a significant alcohol intake, 2% were co-infected with Hepatitis B and C and 3% were co-infected with both Hepatitis C and HIV. The genotypes were 44 G1a; 3 G1b; 6 G2; 34 G3; 1 G4 and 13 unknown.

There is a high rate of sustained virological response (SVR) being achieved with 61 patients having achieved SVR (82%). 13 patients needed to re-start treatment. 37 have SVR 12 pending. 3 patients have relapsed.

Of the remaining 92 known RNA positive patients within the clinic, 40 identified within our service have been treated elsewhere during the peak of the Covid-19 pandemic. 24 SVR blood tests were performed for the patients treated in other locations. 21 patients are approved to start treatment. 9 are awaiting genotyping and transient elastography. 5 are no longer patients of the primary care clinic and attempts have been made to arrange onward referrals to Hepatology services in their new locations and 5 patients have died.

Conclusion Persons experiencing homelessness often have difficulty accessing healthcare. By facilitating access to Hepatology services tailored to their needs at a site where they access primary care and receive opiate substitution therapy, favourable SVR rates can be achieved with significant risk reduction.

P034 IMPACT OF KAFTRIO® ON TACROLIMUS LEVELS AND LIVER GRAFT FUNCTION IN LIVER TRANSPLANT RECIPIENTS

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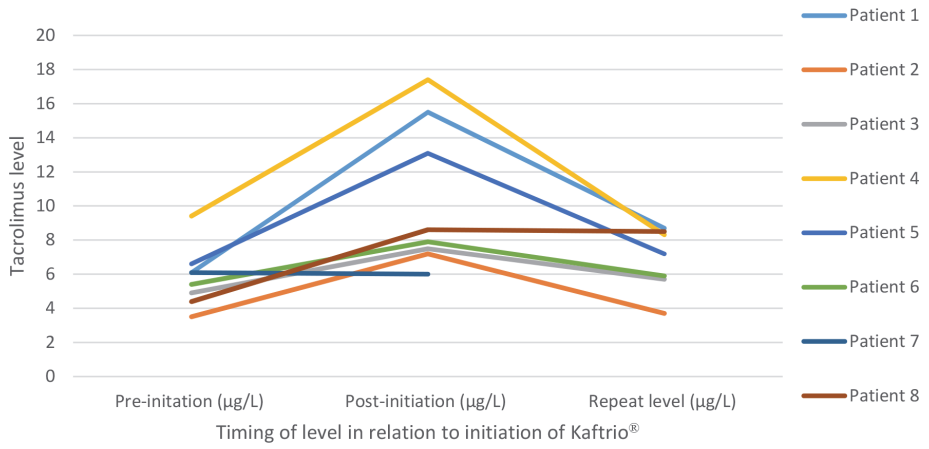
Introduction Cystic fibrosis transmembrane conductance regulator (CFTR) modulators have been shown to increase lung function in Cystic Fibrosis (CF) patients who have two F508del mutations or one F508del combined with any other mutation.[2] In non-transplant patients, trial data for liver function test (LFT) abnormality reported similar rates of transaminase elevation with CFTR modulators and placebo groups.[1] There is limited data and experience of Kaftrio® in liver transplant (LT) recipients.

Methods Patients were identified through referrals to the liver transplant team for monitoring of their tacrolimus levels by the liver transplant multidisciplinary team (MDT). Prospective data was collected from electronic patient records. Our proto-

Abstract P034 Table 1 Liver function tests at baseline (B) and after initiation (R) of Kaftrio® in liver transplant recipients

Patient number	AST (IU/L)		ALT (IU/L)		ALP (IU/L)		GGT (IU/L)		Billirubin (IU/L)		Creatinine (umol/L)	
	B	R	B	R	B	R	B	R	B	R	B	R
1	19	25			76	84	18	20	6	17	68	79
2	27	31			83	96	18	18	4	6	115	122
3			12	17	92	123	45	85	8	8	87	82
4	14			22	100	98	12		8	9	82	64
5			17	33	103	108			28	36	86	114
6	21	16			90	70	12	12	5	15	60	62
7	36	37			236	176	47	52	7	8	587	654
8	44	62			158	250	37	76	12	13	80	89



Abstract P034 Figure 1 The impact of Kaftrio® initiation on tacrolimus levels in 8 liver transplant recipients

col, based on our experience in initiating Symkevi® in LT recipients, was to check tacrolimus levels at day 7 and day 14 after initiation and then again at day 28 along with liver function tests (LFTs).

Results Kaftrio® was initiated in 8 LT recipients. Of these patients, six were transplanted for CF-related liver disease (CFLD), one for CFLD and alpha one antitrypsin deficiency (α1-ATD) and one for α1-ATD alone. Four patients (50%) were male and the median age at Kaftrio® initiation was 30 years (range 24–42 years). All patients had stable LFTs and a tacrolimus level that was within the desired therapeutic range prior to initiation.

All 8 patients had stable LFTs following the initiation of Kaftrio® (table 1). There was a clinically significant rise in tacrolimus level in 4 patients (figure 1) and a tacrolimus dose reduction (of 20–37.5%) was required in these patients. The rise in tacrolimus levels was evident at day 7 and levels returned to therapeutic range within one week of dose adjustment. There was evidence of toxicity (defined as a rise in creatinine from baseline or neurological toxicity) in one patient, most likely secondary to the rise in tacrolimus levels (table 1).

Conclusion Our early experience suggests that it is safe to initiate Kaftrio® in LT recipients. As anticipated, close therapeutic drug monitoring (TDM) of tacrolimus is necessary. We are continuing to monitor these patients to confirm that there are no longer-term effects on liver graft function or tacrolimus levels. Based on the findings of this case series, we recommend LT recipients being initiated on Kaftrio® have weekly LFT and tacrolimus level monitoring for the first two weeks and then monthly for a further three months, until further data is available on the drug-drug interaction and its implications for tacrolimus dosing.

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P035 A CASE SERIES HIGHLIGHTING THE MEDICAL, PERSONAL AND FINANCIAL IMPACT OF PRESENTING WITH ACUTE PORTOMESENTERIC VEIN THROMBOSIS AT ROYAL FREE HOSPITAL

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Background/Aim Acute portomesenteric vein thrombosis (PVT) follows an unpredictable disease course with varying severity and is associated with significant morbidity and mortality. Complications include intestinal ischaemia/infarction, multiorgan failure and death. Treatment objective is restoration of portomesenteric blood flow, with either anticoagulation or thrombolytic therapy. At Royal Free Hospital, systemic thrombolysis is used first line as part of a low dose thrombolysis protocol with multidisciplinary input from hepatology, haematology and interventional radiology. We present a case series of acute PVT and its management, outcome and the financial cost of treatment.

Methods All patients who presented/were transferred to Royal Free Hospital between January 2019 to April 2021 with acute PVT and underwent the low dose thrombolysis protocol were identified from pharmacy dispending records. Patient demographics, presentation, investigations, management, cost of treatment, complications and outcomes were collected through the electronic patient record and analysed through summary statistics.

Results 41 patients were identified, with an average age of 43 years. 26 patients had a known thrombotic risk factor or were subsequently found to have one. Only 5 patients had previous liver disease. Presenting symptoms included abdominal pain (n=39), nausea/vomiting (n=11), constipation (n=5) and diarrhoea (n=5). Systemic thrombolysis was given as initial treatment to 40 patients. All patients had continued symptoms despite initial therapeutic anticoagulation. 13 of these patients subsequently underwent a transjugular intrahepatic portosystemic shunt with subsequent catheter directed thrombolysis for 12 patients. 3 patients required mechanical thrombectomy due to lack of symptom resolution.

Post final treatment, 45% of patients had partial recanalization, 17.5% had complete recanalization whilst 37.5% of patients had no improvement in clot burden. Average duration of thrombolysis was 4.61 days. The cost incurred with the dispensing of alteplase came to an average of over £4657 for each patient.

55% of patients had minor complications from thrombolysis: minor oozing, epistaxis and drop in fibrinogen levels. 2 patients developed major complications: variceal bleed and intracranial haemorrhage. 6 patients required surgical intervention due to non-response to medical therapy resulting in small bowel resection. 1 patient died within 24 hours of admission.

Conclusion Using the Royal Free thrombolysis protocol, 62.5% of our patients showed partial or complete recanalization. The study highlights the significant cost associated with just thrombolysis alone. The complexity of the patient population means that the optimal regime/pathway remains to be defined.

P036 IMPACT OF THE FIRST WAVE OF COVID-19 ON THE ERCP SERVICES IN A SINGLE SECONDARY ENDOSCOPY UNIT AT THE NORTH OF ENGLAND: A RETROSPECTIVE ANALYSIS OF THE ENDOSCOPY DATABASE AT ROYAL LANCASTER INFIRMARY

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Background British Society of Gastroenterology (BSG) recommended that the endoscopy units to perform ERCP during the COVID-19 pandemic for obstructive biliary pathologies in an emergency. We aim to assess the local performance of ERCP during the COVID-19 first wave at our local endoscopy centre.

Methods All ERCP procedures performed from January 2020 to Jun 2020 were retrospectively assessed and compared with procedures performed between January-Jun 2019 at Royal Lancaster Infirmary. Indications of ERCP, success rate, and complications were studied separately. Correlation analysis was conducted using Spearman's rank correlation coefficient. The binary logistic regression model was carried out to compute factors associated with successful ERCP. The significance is established when the two-sides P-value < 0.05. Statistical