P073 ABSTRACT WITHDRAWN

P074 PATIENTS WHO DEVELOP HEPATOCELLULAR CARCINOMA HAVE HIGHER RISK aMAP SCORES UP TO 5 YEARS BEFORE DIAGNOSIS

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Background Many patients with hepatocellular carcinoma (HCC) are diagnosed too late for potentially curative therapies and there is an unmet need for earlier detection. A recent international study assessed the 'aMAP' score (age, male gender, albumin-bilirubin, platelets) for stratifying chronic liver disease patients into low (<0.2%), medium (0.4–1%) or high (1.6–4%) annual risk of developing HCC [Fan R et al, *J Hepatol* 2020]. However, the data was predominantly from patients with chronic viral hepatitis in tertiary centres, with potential for referral bias. The aim of our study was to assess whether aMAP scoring could have identified patients who developed HCC in an unselected UK population including non-viral liver diseases.

Methods A liver cancer database was used to identify all patients diagnosed with HCC over a 10-year period at a major acute hospital serving a population of 675,000. Clinical data included demographics, laboratory parameters, aetiology and stage of liver disease. The aMAP scores were calculated using blood tests from 1–5 years prior to HCC diagnosis to classify patients as low, medium or high risk.

Results We identified 226 patients diagnosed with HCC between 2010 and 2020. Median age at diagnosis was 72 years, 181 (80%) were male and 215 (95%) were of white ethnicity. Aetiological factors were alcohol 78 (35%), non-alcoholic fatty liver disease 68 (30%), chronic viral hepatitis 54 (24%) and others 20 (9%). There was no prior history of liver disease in 83 (37%). Only 56 patients (25%) were in a surveillance programme and just 47 (21%) were Barcelona Clinic Liver Cancer (BCLC) stage A or lower at diagnosis.

However, a medium or high risk aMAP risk score was identifiable prior to HCC diagnosis in 99% at 1 year, 97% at 3 years and 96% at 5 years. A high risk aMAP score alone was found in 76% at 1 year, 73% at 3 years and in 67% at 5 years prior to diagnosis with HCC.

Conclusions Our study examined a 'real world' population, representative of the broad clinical spectrum of UK liver disease. We confirmed most HCC cases were diagnosed at a non-curative stage and were outside of formal surveillance. Importantly, we demonstrated the vast majority of patients with HCC have higher risk aMAP scores identifiable up to 5 years before diagnosis. Use of aMAP could improve targeting of HCC screening and our findings would support further, prospective evaluation in people with chronic liver disease in the UK.

P075 UTILISING FRAX MODEL TO MANAGE BONE DISEASE (OSTEOPOROSIS) IN A NURSE-LED CLINIC FOR CIRRHOTIC PATIENTS

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Introduction Bone disease (BD) is an important complication of chronic liver disease with prevalence between 12% -55% in cirrhotic patients. Osteoporosis is the most encountered BD type that may lead to fracture and is the only cirrhosis complication that remains after transplantation. Screening for BD using DEXA scan should be offered to all patient with established cirrhosis. Although FRAX model has not been studied in cirrhotic population, it may be a useful tool in the clinic setting to assess fracture risk with potential to reduce the use of DEXA scan.

Method A retrospective review was conducted of cirrhotic patients attending our stable cirrhosis clinic during the 1st year of its establishment. Review included demographic data, aetiology of liver disease, height, weight and fracture incidents. FRAX score was calculated and used to triage the

Abstract P075 Figure 1 Patients groups classified by FRAX model