analysis into patients who recovered or died depending on ward based care versus ITU.

Conclusion COVID pneumonia influenced the outcome of patients admitted with hepatic decompensation resulting in increased mortality. Alcohol was the commonest cause of underlying liver disease in both Pre-COVID and COVID period. Age, nature of hepatic decompensation (Gastro-intestinal bleeding, hepatic encephalopathy, spontaneous bacterial peritonitis) CLIF-C score for patients referred to ITU and average hospital stay was not much different in both the groups. The median MELD and ACLF grade were higher in patients who died compared to those who recovered.

P084 A MELD SCORE ≥ 19 PRIOR TO ANTI-THYMOCYTE GLOBULIN THERAPY FOR STEROID RESISTANT T CELL-MEDIATED REJECTION PREDICTS POOR 5-YEAR TRANSPLANT FREE SURVIVAL

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Background and Aims Steroid resistant T cell-mediated rejection is a risk factor for graft loss and patient mortality post liver transplant (LT). Anti-thymocyte globulin (ATG) therapy has been demonstrated to be an effective treatment for this condition but long term follow up data are limited. We aimed to identify risk factors for reduced 1-year and 5-year LT free survival post ATG use for steroid resistant T cell-mediated rejection.

Method We performed a retrospective observational study evaluating all LT patients who received ATG for steroid resistant cellular rejection between 01/2007–01/2020 at King's College Hospital. ATG was administered based on institutional practice and clinician choice. Patients were excluded if they received ATG without prior steroids. Clinical, demographic and laboratory data were collected and univariate analysis were performed.

Results 39 LT patients fulfilled inclusion/exclusion criteria. 13 did not achieve a 1-year LT-free survival and a further 5 did not achieve a 5-year LT free survival. Age, female sex, LT for

an autoimmune liver disease, redo LT and pre-ATG AST, tacrolimus level, creatinine, albumin, haemoglobin, white cell count and differentials did not predict 1-year LT free survival. Variables predicting reduced 1-year LT free survival were:- increased time from LT when receiving ATG (AUC 0.82, 95% CI 0.69–0.96), histological overlap with chronic rejection (AUC 0.75, 95% CI 0.57–0.93), increased pre-ATG bilirubin (AUC 0.80, 95% CI 0.66–0.94), INR (AUC 0.71, 95% CI 0.52–0.89) and MELD (AUC 0.86, 95% CI 0.75–0.97). Survival analysis was performed to evaluate risk factors affecting 5-year LT free survival. Cut-off values for pre-ATG MELD and days post-LT receiving ATG were determined by Youden's Index. Histological overlap with chronic rejection (HR 3.33, 95% CI 1.10–10.11), receiving ATG >178 days post-LT (HR 5.86, 95% CI 1.82–18.83) and a pre-ATG MELD ≥ 19 (HR 8.84, 95% CI 3.25–24.04) (see figure 1) predicted a reduced 5-year survival.

Conclusion ATG use in patients with steroid resistant T cell-mediated rejection with a MELD ≥ 19 is associated with sub-optimal 5-year LT-free survival. ATG use and re-transplant candidacy needs to be re-evaluated in this clinical cohort.

P085 VIRTUAL TRANSPLANT ASSESSMENT IS FEASIBLE AND MAY INCREASE ACCESS TO LIVER TRANSPLANTATION

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Background It has been demonstrated that patients living further from a transplant centre are less likely to be transplanted in the UK and abroad. King's College Hospital (KCH) has collaborated with teams in Plymouth, North Bristol and Belfast to establish satellite transplant centres (SLTCs) to address this. However, the COVID-19 pandemic threatened to exacerbate this healthcare inequity by reducing travel and stopping patients undergoing transplant assessment at KCH. In response to this, we developed a virtual transplant assessment (VTA) pathway to ensure that patients at SLTCs were not disadvantaged through the pandemic.

Methods Data were retrospectively collected from all patients referred from our SLTCs and discussed at KCH transplant listing meetings between April 2020 and April 2021. Patients were either assessed face-to-face or virtually depending on the 'discussion in principle' (DIP) MDM between KCH and the corresponding SLTC. Demographic (age and sex), clinical (disease aetiology, smoking history, time of referral, time of full discussion and whether the patient was listed for transplant or transplanted) and laboratory data for calculation of prognostic scores were collected from the clinical notes. Continuous variables were analysed for normality using the D'Agostino and Pearson test and patients undergoing face-to-face assessments were directly compared with those undergoing VTA by *t* test if normally distributed or Mann-Whitney *U* test if non-normally distributed. Categorical data were analysed using Fisher's exact test. Time from listing to transplantation was compared between both groups by survival analysis.

Results During this time, 19 patients underwent VTA and 30 patients underwent face-to-face assessment. No patients were fully assessed from SLTCs between April and July 2020.

Abstract P084 Figure 1