



**Abstract P096 Figure 1** Ammonia production, normalised to level with no flurofamide present

(300 mM) in the medium used, but urea fell in cultures without flurofamide relative to cultures with higher concentrations of the compound.

**Conclusion** In an in vitro system, flurofamide inhibited virtually completely the production of ammonia from urea by colonic microorganisms; this occurred at concentrations which might feasibly be obtained in vivo.

#### P097 ACUTE VARICEAL BLEEDING IN A LARGE TEACHING HOSPITAL: A 5-YEAR ANALYSIS

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Acute variceal bleeding (VB) remains a major cause of death in cirrhosis/portal hypertension. We aim to assess the characteristics, therapies delivered and outcomes of patients presenting with VB in a large teaching hospital.

A retrospective analysis was performed on all patients presenting with acute UGIB who underwent a gastroscopy between March 2015 and February 2020. Data was collected where UGIB was deemed secondary to varices from electronic records to assess findings at endoscopy, therapy applied, rebleed rates and mortality.

A total of 2324 patients presented with UGIB. 239 presentations involving 196 patients had varices reported. 155 cases underwent therapy for acute VB as cause for UGIB, with varices felt not to be the primary cause in the remaining 84. Median age was 54 years (IQR 46–67). 65% (n=100) were male. Clinical presentations were haematemesis only 35% (n=55), melaena only 26% (n=41) or both 38% (n=59). 56% (n=87) gastroscopies were undertaken ‘out of hours’. The commonest endoscopic finding was oesophageal varices in 98% (n=152).

Treatment was undertaken at first endoscopy in 93% (n=144), comprising banding (86%) and glue injection (7%). 17% (n=27) of patients required insertion of Sengstaken-Blakemore tube. The remaining 7% (n=11) underwent their first treatment at further gastroscopy (within 7 days).

32% (n=49) of patients had repeat gastroscopy within 7 days, where 90% were due to clinical evidence of rebleed. 23 patients required repeat endoscopic therapy and 10 patients underwent Sengstaken-Blakemore tube insertion.

30% (n=70) of patients required ICU admission. 16% (n=25) underwent TIPS procedure.

30-day rebleeding rate was 24% (n=37). 30-day mortality was 17% (n=27) with 67% attributable to UGIB or subsequent decompensated cirrhosis with multi-organ failure.

On subgroup analysis, ICU admission was significantly associated with increased mortality (OR 3.46, 95% CI 1.46 to 8.22,  $p < 0.01$ ) but rebleeding (OR 1.35, 95% CI 0.54 to 3.23,  $p = 0.53$ ) or having a gastroscopy ‘out of hours’ (OR 1.48, 95% CI 0.55 to 3.95,  $p = 0.43$ ) were not.

Receiver operating characteristic (ROC) curves showed better predictive ability of MELD score than Child-Pugh score for 30-day mortality (AUC 0.92 vs 0.72), with MELD score of  $> 18$  significantly associated with increased mortality (OR 7.70, 95% CI 0.04 to 0.35,  $p < 0.01$ ) similar to published data.

Mortality and rebleed rates following acute VB is in keeping with national data. More than half of patients undergo gastroscopy out of hours emphasizing the need for 24/7 access to therapeutic endoscopy. MELD score of  $> 18$  appears to be a strong predictor of mortality and can be used in clinical practice to consider early critical care involvement.

#### P098 CIRRHOCARE®-A PILOT STUDY OF DIGITAL HOME MANAGEMENT OF ADVANCED CIRRHOSIS TO DETERMINE FEASIBILITY AND UTILITY TO DIAGNOSE NEW DECOMPENSATION EVENTS

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**Background and Aims** Patients discharged from hospital following acute decompensation are at high risk of new complications and need close follow-up, limited currently by the growing burden of cirrhosis and impact of COVID-19. Specialist liver care in the community is an unmet need, to reduce hospital exposure and manage new decompensation events.

**Methods** We included 20 patients with cirrhosis and recent acute decompensation. Commercially available devices and a smartphone (+SIM card) were given to all patients for