Abstract PWE-6 Figure 1  Forest plot of all included studies

developed based on the one used for PubMed, Medline, and Embase. We include prospective and retrospective RCTs that assessed the efficacy and hepatotoxicity of biologics in IBD patients. Hepatotoxicity was defined as AST and/or ALT >2x upper limit of normal or cholestasis. We used Review Manager 5 (RevMan5) to analyse the data. We calculated the Odds ratio (OR) with a 95% confidence interval (CI). We assessed heterogeneity using the I² statistic.

Results We identified 862 records in total. After we had removed duplicates 564 records were left for review. Four studies did not report on how participants were randomized to treatment groups or how allocation concealment was achieved, we rated these studies at unclear risk of bias for these domains. All our included trials mentioned adverse effect and I2= 0%, when the whole seven studies were involved assessed heterogeneity using the I² statistic.

Conclusion This study summed up the broad information of biologics on liver which are analysed statistically, and result is summarized in figure 1. They were no presence of any heterogeneity among studies by (Chi²= 2.21, df = 6, P = 0.90, and I²= 0%), when the whole seven studies were involved for analysis. Our meta-analysis was conducted on the fixed effects model, with the (0.770, 95% CI [-0.630, 0.957], and P = 0.02). Hepatotoxicity was not related to any TNF-α antagonist. Thiopurine induced liver injury occurred more frequently within the first months of treatment, 50% of cases within the first 3 months. Although, risk of hepatotoxicity above the third quartile (6-MMPR > 5,300) was 5 times that below the third quartile (11.4% vs 2.3%, P < 0.05).

Conclusion This study summed up the broad information of incidences of biologic related hepatotoxicity in IBD patients in clinical practice setting. When hepatotoxicity occurred, the treatment was withdrawn in thirty one percent of patients, but an important percentage, forty-four was able to continue full dose of thiopurine once the dose was temporarily adjusted. This group of patients had a dose-dependent hepatotoxicity rather than an immunologic hepatitis.

REFERENCE


Abstract PWE-7 Figure 1  Clinic diagnoses in patients referred through iLFT

Introduction Mortality from chronic liver disease (CLD) in the UK has risen 400% since 1970, and incident liver function tests (LFTs) are abnormal in 20% of cases. Routine intelligent liver function testing (iLFT) was launched in NHS Tayside, Scotland in 2018. If the requestor provides BMI, alcohol intake and co-morbidities, patients with abnormal LFTs have reflex tests, including non-invasive fibrosis scores, automatically without further venepuncture. GPs are provided with automated diagnoses and management plans: secondary care referral for fibrosis assessment or treatment; primary care follow up with ultrasound or repeat LFTs; or primary care management alone.

Methods Patients undergoing iLFT between August 2018 and August 2019 were tracked to identify iLFT outcome(s), if they were referred to liver services, and their final clinic diagnosis.

Results 2362 iLFT requests were received. No cascade occurred in 540 cases, either due to normal LFTs (81.5%) or insufficient clinical data.

There were 2017 iLFT outcomes from 1822 patients. The most common outcome was elevated ALT without fibrosis (n=430) followed by alcohol related liver disease without fibrosis (n=267).

Secondary care referral was recommended for 474 patients, of which 373 were referred (78.9%). A further 105 of 199 (52.8%) were referred following the outcomes of iLFT-recommended tests. Just 88 of 1141 (7.7%) patients recommended for primary care management were referred.

Liver clinic diagnoses were available for 248 patients. The most common diagnosis was NAFLD without fibrosis (27.8%) followed by ARLD with fibrosis (12.5%). 19 patients had malignancy (non-liver n=18, neuroendocrine n=1). Figure 1 shows all diagnoses. Of patients with elevated ALT and Gamma-GT only, with no declared risk factors for CLD, 66.7% (n=20) had NAFLD.

iLFT diagnosis concurred with clinic diagnosis (exact match; match other than no evidence of advanced fibrosis following assessment; or descriptive iLFT outcome with no identified risk factor with a ‘fail safe’ to prompt referral) in 225 cases (90.7%). In the remaining cases, iLFT failed safe despite a diagnostic inaccuracy (22/248), and only had a wrong diagnosis with no fail safe in 1 case; a patient with haemochromatosis with transferrin saturations below the upper limit of normal.

Conclusions In the real world iLFT rapidly and safely diagnoses CLD while ensuring patients with other problems, such as