designing effective PA/exercise interventions in this patient population to ensure maximum uptake and adherence.

PERCUTANEOUS CHOLECYSTOSTOMY RATES ARE INCREASED FOLLOWING COVID-19 INDUCED DISRUPTION TO ELECTIVE SURGICAL PATHWAYS

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Introduction The COVID-19 pandemic has led to major service disruptions, including the cessation of elective laparoscopic cholecystectomies (LC), causing delays in managing symptomatic gallstones. We hypothesised that this would lead to an increased need for percutaneous cholecystostomy (PC) for acute cholecystitis.

Methods We performed a retrospective cohort study in a single NHS trust. We included all patients who underwent either LC or PC during the periods of March 1st – August 31st over the years 2019 and 2020. Patient data was obtained from prospectively maintained patient electronic notes. Data are presented as median and interquartile ranges for continuous data and the percentages for categorical data and compared with Mann-Whitney U-test and Fisher's exact tests respectively.

Results We observed a substantial reduction in the number of LC performed in 2020 (n=99) compared to 2019 (n=198), whilst the number of PC performed in 2020 (n=35) was more than double that in 2019 (n=17) (Figure.1). This increase in numbers persisted even after our LC service was restarted. Comparing the patients who underwent PC in both

PERCUTANEOUS CHOLECYSTOSTOMY

Abstract PWE-20 Figure 1 Percutaneous cholecystostomy

years, there were no significant differences in age (2019: 68 (45-76) vs 2020: 72 (57-81), p=0.41), comorbidities (Charlson comorbidity index≥4: 10 (59%) vs 16 (46%), p=0.56), or in-hospital mortality (2019: 2 (12%) vs 2020: 3 (9%), p=0.99).

Conclusions These results show how the cessation of LC service was directly related to increased numbers of invasive 'damage control' procedures for acute cholecystitis, emphasising the importance of maintaining COVID-secure surgical pathways. The numbers of PC remained high even after the restart of LC service, consistent with a 'COVID shadow' resulting from interruptions to elective services that impacts patient care for a prolonged period.

HEPATOCELLULAR CARCINOMA SURVEILLANCE: ULTRASOUND IMAGE QUALITY AND IMPLEMENTATION OF THE US LI-RADS CLASSIFICATION

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Introduction 6-monthly ultrasounds (US) are offered for hepatocellular cancer (HCC) surveillance in at-risk populations. US image quality is variable, depending on patient and liver parenchymal factors, as is reporting of findings. The aim of this audit was to examine reporting practice in our institution, and the proportion of compromised surveillance ultrasounds in our large surveillance cohort.
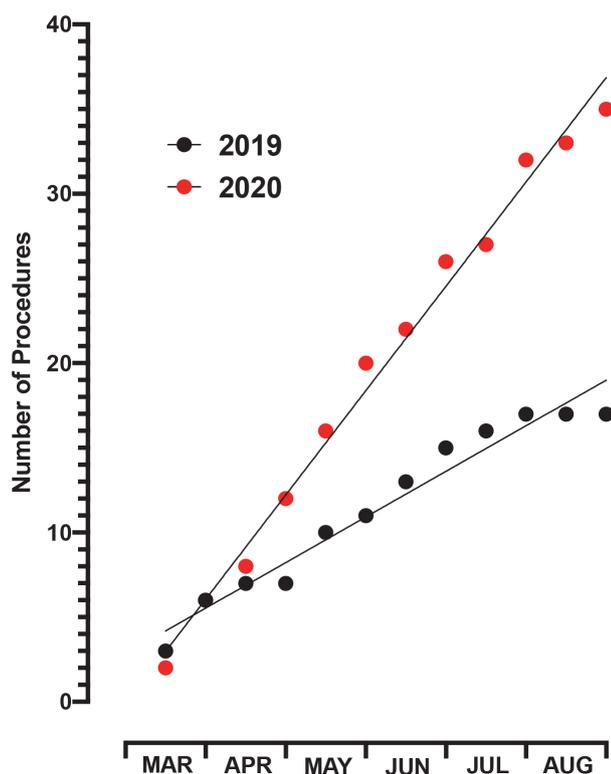
Methods Electronic records for 50 patients with established cirrhosis undergoing HCC US surveillance were interrogated. The three most recent US were reviewed for reporting of image quality and limitations. Images from a single surveillance visit were then retrospectively reviewed and scored according to the US LI-RADS criteria by two Consultant Radiologists with more than 10 years' experience reporting abdominal US, with a third, consensus read to resolve disagreement.

Results Patients had a mean age of 66 (range 47-84; 16 females, 34 males). Mean surveillance duration was 5 years. All patients had established diagnosis of cirrhosis, most commonly due to non-alcoholic steatohepatitis (NASH) (44%) or alcoholic liver disease (38%). 94/149 (63%) reports commented on quality of images or views. Terminology used for quality reporting were inconsistent amongst reporters. 25/94 (26%) reports used terminology suggesting good or acceptable views and 16/94 (17%) suggested significant limitation to views. The most common reasons cited for poor views were body habitus and overlying bowel gas.

Using US LI-RADS, 47 (94%) patients were classified US-1 (negative), one (2%) patient US-2 (subthreshold) and two (4%) patients US-3 (positive). For image quality, 21 (42%) patients were classified US-A (no limitations), 23 (46%) patients US-B (moderate limitations) and 6 (12%) patients US-C (severe limitations). As expected, there were a higher proportion of severely compromised (LI-RADS US-C) examinations in patients with NASH cirrhosis vs non-NASH cirrhosis (22.7% vs 3.6%; p=0.075).

Discussion There was significant variability in US image quality reporting and terminology. Consistent with prior studies of HCC surveillance in Western populations, a significant proportion of patients had severely limited image quality, most