marked in patients with NASH cirrhosis. Implementation of US LI-RADS at our institution, will standardise reporting and will aid decision-making for clinicians who may wish to consider alternative surveillance imaging, particularly in patients with severely limited US examinations.

PWE-22 ON THE CLIF EDGE: PREDICTING MORTALITY IN ACUTE ON CHRONIC LIVER FAILURE ON INTENSIVE CARE

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Introduction Acute-on-Chronic Liver Failure (ACLF) is an acute hepatic decompensation with organ failure in a patient with cirrhosis¹. It is characterized by a severe systemic inflammatory response and is associated with high short-term mortality and significant morbidity². CLIF-C ACLF is a physiological scoring system, derived from the largest internationally agreed registry, used to grade the severity of ACLF. This may be used to predict mortality and guide acute management, including consideration of orthotopic liver transplantation.

Methods We retrospectively collected data on patients admitted to our Intensive Care Unit (ICU) with ACLF between January 2016 and September 2018. Patients were identified from our online critical care database and case notes were obtained, where possible, from our medical records for analysis. We retrospectively calculated CLIF-C scores for patients at the time of admission to ICU and 48 hours later. Other data collected included the cause of patients' cirrhosis, ICNARC scores, length of hospital and critical care admission and patient outcomes.

Results Data on 23 patients were analysed from this period; 11 had a new diagnosis of cirrhosis during their acute admission and 12 were previously diagnosed; Alcoholic Liver Disease was the most common cause of cirrhosis (65%). Mean CLIF-C scores at admission and 48 hours were 61/62 respectively with predicted mortality of 64% at 1 month and 85% at 12 months. 11/23 (48%) died during admission and 12/23 (52%) survived to discharge; 2 of the patients who survived died within the following 12 months, increasing our observed 12 month mortality to 57%. Patients who died had higher CLIF-C scores than those who survived (mean 62/66 vs. 60/59), with a greater degree of observed organ dysfunction and longer critical care admission (7 days vs. 5 days), however these findings were not statistically significant.

Conclusions CLIF-C scores were not shown to accurately predict patient outcome in this analysis; the observed 12 month mortality of 57% was markedly lower than the predicted mortality (85%) using this scoring system. There was, however, some correlation between higher predicted mortality and actual mortality. Pre-existing cirrhosis, longer times from hospital admission to ICU admission and higher ICNARC scores were also associated with worse outcomes. Further studies with a larger sample size are warranted to assess the utility of CLIF-C ACLF in patient prognostication and to inform critical care management.

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PWE-23 LIVER TRANSPLANT FOLLOW UP APPOINTMENTS IN SECONDARY CARE: COSTS AND THE PATIENT EXPERIENCE

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Introduction The 2020 BSG Adult liver transplantation guideline suggests that most patients can be discharged from tertiary to secondary-care services 3 months post-transplant¹. Despite this recommendation many patients remain under tertiary care follow up for many years.

As virtual clinics become more ubiquitous the barriers to patients accessing tertiary care services may reduce but some issues still need face to face contact. Liver transplant is a high cost intervention at £21,000-£48,000 per quality adjusted life year². Therefore, it is important to assess post-transplant costs, quality of care and quality of life in transplant patients followed up solely in secondary care in a district hospital over a 20 year period.

Method The EQ5D-5L quality of life tool³, clinic experience and travel costs questionnaires were sent to 30 patients, who had received a liver transplant and were under local follow up. Data on the number of local follow up clinic appointments that these patients had attended was also collected.

Results 25 patients responded. There EQ5D-5L scores are shown in table 1.

The combined mean EQ5D-5L tariff was 0.78; which is comparable to the data published by *Bryan et al.*, from the Queen Elizabeth and Royal Free Hospitals (EQ5D tariff 0.77)⁴.

The clinic experience questionnaire showed high levels of patient satisfaction with their secondary care follow up appointment, across all domains.

The travel costs for those patients who did not benefit from NHS patient transport services spent on average £36 more to attend clinics at tertiary care as opposed to the secondary care settings. For this cohort to receive follow up exclusively in tertiary care would, on average, equate to personal travel costs of £1158.34 to date.

Conclusion This study finds that patients who receive secondary care follow up after liver transplant have high levels of satisfaction with their clinic appointments and good quality of life. They also benefit from a significant reduction in travel time and costs.

Even in an era of increasing utilisation of virtual clinics, tertiary follow up offers no clear benefit to the patient and may increase costs to the patient and/or health service as a whole. Secondary care follow up of the post-transplant patient

Abstract PWE-23 Table 1 Percutaneous cholecystostomy

Table 1.	Mobility	Self-care	Usual activities	Pain/Discomfort	Anxiety/Depression
1	56% (n=14)	96% (n=23)	48% (n=12)	48% (n=12)	52% (n=13)
2	24% (n=6)	8% (n=2)	24% (n=6)	16% (n=4)	32% (n=8)
3	12% (n=3)	0% (n=0)	24% (n=6)	32% (n=8)	12% (n=3)
4	8% (n=2)	0% (n=0)	4% (n=1)	4% (n=1)	4% (n=1)
5	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)

is an effective way of reducing demand on tertiary services, whilst ensuring high quality patient care.

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PWE-24 MID HAMPSHIRE COMMUNITY PATHWAY FOR IDENTIFICATION OF THOSE AT RISK OF SIGNIFICANT LIVER INJURY

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Aim to risk stratify patients at risk of liver disease using fibroscanning in the community

Methods BSG guidance¹ recommends first line testing should use either FIB-4 or NAFLD fibrosis score, followed by second-line testing which involves a quantitative assessment of fibrosis through the use of Enhanced Liver Fibrosis testing or Fibroscan. In adults with alcohol related liver disease, drinkers at harmful levels should undergo risk stratification with clinical assessment and Fibroscan.

West Hampshire CCG commissioned a one year pilot community Fibroscan service for 18 participating GP surgeries. A FIB 4 (chosen as costing 12p/test) was calculated for those with:

1) Diabetes

• **BMI >35** • Alcohol intake >50 units/week for men, >35 units/week for women. Opportunistic screening took place at Inclusion, the community alcohol support service.

Those with a FIB 4:

- <1.3 were given lifestyle advice
- 1.3-3.24 were referred for a Fibroscan, which took place at clinics being held in GP practices in each of the 4 Primary Care Networks in Mid Hampshire, undertaken by a trained Band 3, moving between each practice each day (est cost £35/scan). Fibroscan Results

- o Fibroscan <8: given lifestyle advice including when a next Fibroscan would be indicated

- o Fibroscan 8-15: lifestyle advice and consideration of hepatology referral

- o Fibroscan > 15: referred to hepatology

- >3.25 referred to hepatology, unless aged >85.

All Fibroscan appointments used a Making Every Contact Count approach, delivering brief advice about risk factor modification or signposting to clinically relevant services such as commissioned community weight loss and alcohol support services.

Results from first 12 months:

Of those screened with FIB 4:

- FIB 4 1.3-3.24: 1129, community Fibroscan offered
- 1115 Fibroscan Results
- <8 896 (80%)
- 8-15 159 (14%)

- >15 60 (5%)

- FIB 4 >3.25: 84, of which 53 were referred direct to hepatology clinic (31 were aged 80+, age being numerator in FIB 4, with no other abnormality on subsequent Fibroscan). Service subsequently placed an upper age limit on FIB 4.

Results show that of those with a FIB 4 >1.3, 9% had a Fibroscan >15, this group has been predominantly obese.

DNA rate for Fibroscan 1%

Feedback no complaints received from patients or GPs.

Conclusion 9% of those with an elevated FIB 4 had advanced chronic liver disease on Fibroscan, and had not previously been identified. This pilot used FIB 4 (cost 12p) and fibroscanning in GP surgeries, using a trained Band 3 (est cost £35/scan). This was therefore less costly than a hospital based scanning programme (estimated as costing £75/scan).

Case finding by FIB 4 and fibroscanning has already been shown to be effective in detecting liver disease². This pilot demonstrates a scanning service can be portable, bringing the service closer to patients and overcoming barriers to access. It is low cost compared to hospital based alternative delivery models. Further work is planned to refine the delivery model and increase the positive predictive value of the service.

High patient and GP satisfaction reported.

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PWE-25 DEFERRED LIVER TRANSPLANT WAITLISTING DUE TO PREHABILITATION SUPPORTS EARLIER REFERRAL IN ALCOHOL RELATED LIVER DISEASE

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Introduction In the UK, alcohol related liver disease (ArLD) is the leading indication for liver transplant (LT) wait-listing. Outcomes post LT for ArLD compare very well with those for other aetiologies, with low rates of histological disease recurrence and graft loss. Despite this, studies suggest a prejudice remains towards ArLD amongst medical professionals and therefore acts as a potential barrier to both access and timely referral for LT. All LT centres provide assessment with alcohol specialists to risk stratify & attempt to predict relapse risk, thus enabling appropriate listings. Whilst achieving abstinence leads to improvement in some, there is no requirement for an enforced abstinence period prior to referral for advanced disease patients who are otherwise suitable candidates. This may lead to missed opportunities for some potential recipients. We looked at the outcome of our assessments in ArLD patients to identify what proportion may have benefitted from earlier referral.

Methods We conducted a retrospective evaluation of all LT assessments for chronic liver disease in a single transplant centre between April 2017 - March 2019. Electronic patient records were interrogated to establish patient demographics, severity of disease at referral and assessment outcome.

Results ArLD was the primary aetiology in 184/371(49.6%) assessment referrals (131 males (71%), 53 females (29%)) with median MELD = 17 (range 6-36); median UKELD = 55 (range 42-72). 170/184 (92%) had ascites at point of referral and of these 29% had undergone >5 drains. The LT