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