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

REFERENCES

1. Millison C, Considine A, *et al.* Adult liver transplant: UK clinical guideline: surgery and post-operation. *Frontline Gastroenterology*.2020;**11**:385-396
2. Longworth L, Young T, *et al.* Midterm cost-effectiveness of the liver transplantation program of England and Wales for three disease groups. *Liver Transplantation*.2003;**9**:1295-1307
3. Herdman M, Gudex C, *et al.* Development and preliminary testing of the new five-level version of EQ-5D. *Qual Life Res.* 2011 Dec; **20**:1727-1736
4. Bryan S, Ratcliffe J, *et al.* Health-related quality of life following liver transplantation. *Qual Life Res.*1998;**7**:115-120

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

¹Harriet Gordon*, ²Rory Honney, ³Andrew Baring, ³Amanda Waite, ³Claire Jackson, ³Ben Inglis. ¹Hampshire Hospitals Foundation Trust, Winchester, UK; ²West Hampshire CCG, Eastleigh, UK; ³Mid Hampshire Healthcare, Winchester, UK

10.1136/gutjnl-2021-BSG.214

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.

REFERENCES

1. Newsome PN, *et al.* *Gut* 2017;**0**:1-14. doi:10.1136/gutjnl-2017-314924
2. Chalmers J, *et al.* *Frontline Gastroenterology* 2020;**11**:86-92

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

Victoria Appleby*, Laura Burke, Richard Parker, Ian A Rowe, Rebecca L Jones. *The Leeds Liver Unit, Leeds, UK*

10.1136/gutjnl-2021-BSG.215

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

multidisciplinary team (MDT) supported listing in 70/184 (38%). 105/184 (57%) were not listed and 9/184 (5%) did not complete the assessment. Of the 57% not listed, 33% had an improving clinical trajectory or alternative treatment option e.g. TIPSS. 24% were too high risk due to comorbidity and 17% were thought to have too high a risk of dependency relapse. However, 19% required further optimisation for frailty or malnutrition and had their assessment conclusions deferred.

Conclusion Our data show that one fifth of patients assessed for ArLD require optimisation which prevents their listing. Such candidates are usually frail and/or malnourished and represent late stage disease. These may be surrogate markers of late presentation or late referrals e.g. in the case of > 5 paracenteses. New BSG guidelines in 2020 recommend early referral (at three months if no improvement, or earlier if urgent late presentations) for patients with decompensated ArLD. This enables alcohol and allied health specialists additional time to work with patients in order to achieve favourable outcomes. This should provide reassurance and empower referring clinicians, especially those that do not have access to specialist alcohol services in their units.

PWE-26 NORTHERN IRELAND EXPERIENCE OF KAFFES STENTS USAGE FOR BILIARY ANASTAMOTIC STRICTURES POST LIVER TRANSPLANT

¹Rebecca O' Kane, ²Rebecca O' Kane*, ³Neil Mc Dougall. ¹Gastroenterology Registrar, Belfast, UK; ²Gastroenterology Registrar, Belfast, UK; ³Consultant Hepatologist, Belfast, United Kingdom

10.1136/gutjnl-2021-BSG.216

Introduction Biliary anastomotic strictures are isolated, short-length strictures that occur in 10-16% of patients post orthotopic liver transplantation (OLT). The strictures are most common in the first year post OLT but can occur at any time. Management has historically been with repeated dilations and plastic stenting and if this fails to resolve the stricture, hepaticojejunostomy is considered.

Kaffes stents (Taewoong Medical) are a novel type of fully covered self expanding metallic stent with a design that helps reduce the risk of stent migration. Previous randomised trials have illustrated their success with resolving anastomotic strictures when compared to plastic stenting.

Methods The Regional Liver Unit began using Kaffes stents to manage anastomotic strictures in 2018.

A Kaffes stent was used for all post OLT biliary anastomotic strictures that were causing derangement of LFTs provided that there was sufficient space to place the upper end of the stent below the hilum.

The stent was left in situ for 8-12 weeks and second stent inserted at repeat ERCP if stricture not fully resolved. Biliary reconstruction discussed with OLT surgeon if stricture not resolved after 2 stents.

A retrospective analysis was carried out of all OLT recipients who had a Kaffes stent inserted. Patient list retrieved from electronic liver transplant database. Data obtained from ERCP reports and recipient electronic care records.

Results From May 2018 to Aug 2020, nineteen OLT patients had a Kaffes stent inserted.

The median time to stricture diagnosis was 4.5 months (shortest: 0.5 months, longest 147 months). 8 developed a

stricture within 3 months, 5 with 12 months and 6 more than 12 months after transplant.

11 had no previous intervention for their stricture, with remainder having previous plastic stent insertion (prior to Kaffes stent becoming available)

Stents were inserted for a median of 12.5 weeks. Two sizes of stent were used: 40mm length and either 8mm or 10mm width.

15 (79%) patients achieved resolution of the stricture – 10 requiring just one stent, 4 requiring a second stent and 1 requiring a third stent.

4 patients failed to resolve with Kaffes stent - 1 has been relisted for further liver transplant and is undergoing dilatation and straight stents 3 monthly, 1 undergoes intermittent dilatations/plastic stents (not fit for surgery), 1 underwent a hepaticojejunostomy and 1 has been listed for biliary reconstruction surgery.

Conclusions The Kaffes stent is effective in resolving biliary anastomotic strictures post-OLT for over 75% of patients, with the majority just requiring a single Kaffes stent. The reduced requirement for repeat ERCPs should more than offset the cost of a Kaffes stent compared to a plastic stent.

PWE-27 PROFILE OF THE USE OF STATINS IN RELATION TO LIVER FUNCTION TESTS IN CARDIOLOGY PATIENTS

Sonia Moteea*, Jessica Morrison, Carol Firth, Sarah Tinker, Sulleman Moreea. *Bradford Teaching Hospital, Leeds, UK*

10.1136/gutjnl-2021-BSG.217

Background According to NICE prior to starting statin therapy a patient should have liver function tests (LFTs) specifically alanine aminotransferase (ALT) performed¹. LFTs should be repeated at three and twelve months post starting statin therapy¹. Statins are frequently associated with elevated LFTs, especially during first weeks of treatment. However, they are rarely directly associated with causation of severe liver disease². Emerging evidence suggests LFT monitoring for statin therapy is overdone and costly³.

Aims To review the effect of statin therapy on ALT results in Cardiology patients.

Method For the period Jan 2015-Dec 2017 (36 months), we extracted data for all patients admitted under cardiology from our electronic databases: patient demographics; diagnosis on discharge, medication on discharge; LFTs before and after starting statins.

Result During the study period, 4871 patients were admitted with a diagnosis of acute coronary syndrome (ACS). 729 (15%) patients (456 M, mean age 62; 273 F, mean age 66) died during their admission. Of the remaining 4142 patients (2677 M, mean age 64; 1465 F, mean age 68), 1854 (45%) - (1312 M, mean age 60; F 542, mean age 65) where commenced on statin therapy. 654(35%) patients (188 F, 457 M) had LFTs measured on admission. Of these 499 (76%) (151 F, 348 M) had a normal ALT at baseline - 365 (73%) had normal ALT on repeat, 95 (19%) had no repeat test and 39 (8%) had abnormal ALT on repeat. Of the 145 (24%) (37 F, 108 M) with raised ALT at baseline, 18 (12%) had no repeat ALT, 86 (59%) had normal ALT on repeat testing and 42 (29%) had persistently raised ALT. Of the latter 22 (15%) had an ALT worse than at baseline. 13/654 (2%) had ALT > 450 (X10 ULN) during repeat testing – related to alternative