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

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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

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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

medical cause(6), drug-induced (3), no cause found (4). There were no cases of hospitalisation because of raised ALT and no cases of acute liver failure secondary to statins.

Conclusion Only 35% of cardiology patients started on statins had baseline LFTs measured and ¼ had a raised ALT. Most resolved during follow up. Only 2% had a transaminitis with an ALT > X10 ULN. None came to harm from this. Our results, even though not showing good compliance to NICE guidelines, confirm the safety of statins, in keeping with current evidence³. Monitoring of ALT after starting statin therapy only in symptomatic patients appears to be safe and would lead to savings in time and resources.

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PWE-28 'FURTHERING THE FIBROSCAN': PROMOTING THE USE OF TRANSIENT ELASTOGRAPHY IN PATIENTS WITH ALCOHOL DEPENDENCE

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Introduction Early identification of alcohol-related liver disease in patients with alcohol dependence is vital, both to enhance their clinical management and as a potential motivator for abstinence.¹ The current Commissioning for Quality and Innovation (CQUIN) performance target necessitates that at least 20-35% of alcohol-dependent patients are offered referral for transient elastography (Fibroscan) during a >1 night admission.² We aimed to assess and optimise our Fibroscan referral rate to ensure we were meeting this CQUIN target in our district general hospital.

Methods Quarterly data from 1st April 2020 – 31st March 2021 (Q1-4) was retrospectively analysed to determine the Fibroscan referral rate for alcohol-dependent inpatients. Those with known fibrosis, cirrhosis or prior Fibroscan within the last year were excluded. Interventions were then implemented via quality improvement methodology PDSA (Plan, Do, Study, Act) cycles. Existing alcohol liaison and Fibroscan referral pathways were simplified in PDSA #1 and #2, whilst PDSA #3 involved promotional educational programmes. Appointment of designated 'nurse champions' is currently underway for PDSA #4.

Results 128 patients met the inclusion criteria for Fibroscan referral. Between Q1 and Q4, the Fibroscan referral rate improved from 16.7% to 46.2% (Figure 1). The referral rate for patients admitted via the medical take increased from 19% (4/21) to 55% (11/20). However, for those with simply an overnight admission to the Emergency Department Observation ward before next day discharge, the referral rate increased less markedly from 0% (0/3) to 20% (1/5). Of the patients who underwent Fibroscan, 10.8% (4/37) had a significant finding of bridging fibrosis and were referred to hepatology services.

Conclusions This project has been a useful tool in highlighting gaps in our assessment of alcohol-related liver disease. We have demonstrated that our existing practice had failed to meet national performance targets, but that simple yet

Abstract PWE-28 Figure 1 Run chart data of Fibroscan referral rate in inpatients with alcohol dependence

effective interventions have markedly improved Fibroscan referral rates. These are easily reproducible in other trusts, and the implications for both patient care and CQUIN financial payment is clear. Indeed, if current performance is maintained, the trust will receive the maximum £100,000 annual CQUIN payment.² However, there remains scope to continue progressing referral rates, especially in the Emergency Department Observation ward setting, and efforts remain ongoing locally.

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PWE-29 ATTITUDES TO OFFERING INCENTIVES IN THE TESTING AND TREATMENT OF HEPATITIS C

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Introduction Hepatitis C virus (HCV) is now easy to test for and straightforward to treat, but encouraging those most at risk to engage with services can be more challenging. Incentivisation for testing and treating already takes place in some places for HCV as well as for other conditions. However, this is controversial for various ethical and practical reasons. We conducted a survey of people who work within two HCV Operational Delivery Networks (ODNs) to understand current attitudes to incentivisation.

Methods An anonymous online survey (Web Survey Creator[®]) was sent to participants of the Wessex and Southwest HCV ODNs in January 2020. Questions included personal experience of HCV incentivisation and its effect on engagement, opinion of incentivisation and the appropriate value, type and timing of an incentive.

Results There were 32 respondents, representing a range of ODN participants; specialist nurses(13), hepatologists(8), drug & alcohol workers(3), peer support(2), commissioner(1), other (5). 15/32 (46.9%) did not agree with offering financial incentives, 12/32 (37.5%) did agree and 5/32 (15.6%) were undecided.

14/32 (43.8%) had personal experience of financial incentives. 69% of those with experience felt incentives had increased engagement with HCV services and negative