MDM and MDM to first definitive treatment reduced slightly during the CP (43 v 40.5 days and 56 v 55 days respectively).

Conclusions The COVID-19 pandemic had a significant impact on referrals to the HCC MDM, yet HCC surveillance identified the same number of hepatomas. HCC identified by surveillance in the pandemic were more amenable to radical therapies. The fall in the proportion of patients receiving both curative and palliative therapies reflects the fall in incidental treatable HCC during the COVID period. A relatively high proportion of patients received best supportive care in all three years; reflecting an older population with high burden of comorbidities in South Wales linked to socio-economic deprivation. Median waiting times are in excess of the Welsh Government's target of 62 days, suggesting that the current diagnosis and referral process requires revision and resources to expedite therapies.

PWE-33 RITUXIMAB INITIATION, PRESCRIBING AND HEPATITIS B REACTIVATION: RETROSPECTIVE FIVE-YEAR REVIEW

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Introduction Hepatitis B reactivation is a potentially life-threatening complication of immunosuppression in patients with serological evidence of current or past exposure to Hepatitis B Virus (HBV). Rituximab is a widely used B-cell depleting medication widely used to treat haematological cancers and rheumatological disease. The British Society of Rheumatology, British Society of Haematology and the European Association of Study of the Liver guidelines all recommend patients must all be assessed for HBV before rituximab initiation. This is a single-centre five-year retrospective review of our Trusts Rituximab prescribing and HBV screening.

Methods We included all adult patients receiving rituximab between 1st October 2015 and 30th September 2020 at our Trust. Patients were identified using hospital pharmacy Rituximab prescribing logs. Indications, HBV screening bloods and outcomes were collected using electronic records (Allscripts,

Telepath). Patients with incomplete or missing records were excluded.

Results A total of 870 patients were included in this study. Seventy percent (n = 611) were for oncohaematological indications and 30% (n = 258) for rheumatological. There were 606 patients newly initiated on Rituximab during the study period (Table 1). HBV screening improved from 62% to 94% during the study period.

Eighteen patients were positive or equivocal for Hepatitis B core antibody and 1 for Hepatitis B Surface Antigen. Four patients were prescribed lamivudine prophylaxis, 2 Tenofovir and 1 entecavir. The other patients had no treatment or monitoring. Only 1 case was on adequate length of prophylaxis after being referred to the hepatobiliary service. There were no cases of hepatitis B reactivation in the study period.

Conclusions A significant number of patients are not being screened for Hepatitis B core antibodies, despite local education programmes in 2016 and 2018. Low background rates of HBV in the local community may account for low levels of previous and current HBV infections. Education of prescribers, modifications to the initiation pharmacy checklists and simplification of computer request process should help to improve Hepatitis B screening in our patients and avoid potentially life-threatening reactivation.

PWE-34 EVALUATING THE NON-VIRAL LIVER DISEASE BURDEN IN PEOPLE LIVING WITH HIV AND ABNORMAL LIVER ENZYMES

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Introduction Liver disease in the absence of viral hepatitis co-infection is a growing problem in people living with HIV (PLWH). Likely contributors include alcohol excess, metabolic syndrome (MS), and hepatotoxic antiretrovirals (ARV). We aimed to assess the prevalence of hepatic fibrosis and associated risk factors in HIV mono-infected individuals with abnormal liver tests.

Methods PLWH with persistently elevated alanine aminotransferase (ALT) for >6 months were prospectively assessed using transient elastography, AUDIT questionnaire, and screening for MS. Thresholds for clinically significant hepatic fibrosis (CSHF) and cirrhosis were >7.1kPa and >12.5kPa respectively, and hepatic steatosis (HS) by a controlled attenuation parameter (CAP) >237dB/m.

Results Of 274 recruited individuals the median age was 52yrs (IQR 45-59), 93% men, median HIV duration 15yrs (IQR 10-20), and undetectable viral load in 96%. Overall, HS was seen in 169 (61.7%) and CSHF was seen in 54 (19.7%), of whom 19 (35.2%) had cirrhosis and 40 (74.1%) had HS. Alcohol, MS and ARV were implicated in 24 (44.4%), 31 (57.4%), and 15 (27.8%) of patients with CSHF, respectively. No risk factors were identified in 10 (18.5%) with CSHF. In those with CSHF (n=54) versus those without (n=220), no significant differences were seen in baseline demographic or metabolic co-factors, nor ARV use. On binary and multinomial logistic regression lower HDL cholesterol (HR 0.255, 95% CI 0.103-0.629, P=0.003) and diabetes (HR 2.558, 95% CI 1.175-5.571, P=0.018) were independent predictors of CSHF. Both FIB-4 and APRI performed poorly in identifying CSHF

Abstract PWE-33 Table 1 Newly initiated patients on Rituximab (1/10/2015 to 30/09/2020)

Time period	Total number patients (n)	Gender (%)	Serum virology pre-initiation screening		Positive virology detected in patients screened	
			HBsAg	HBcAb	HBsAg	HBcAb
10/15 – 09/16	161	M – 59 F – 41	62% (n = 100)	59% (n = 95)	0%	2% (n = 2)
10/16 – 09/17	121	M – 48 F – 52	73% (n = 88)	62% (n = 75)	0%	4% (n = 3)
10/17 – 09/18	103	M – 37 F – 63	92% (n = 95)	73% (n = 75)	0%	0%
10/18 – 09/19	115	M – 47 F – 53	94% (n = 108)	83% (n = 96)	< 1% (n = 1)	7% (n = 7)
10/19 – 09/20	106	M – 46 F – 54	94% (n = 100)	84% (n = 89)	0%	7% (n = 6)

Abstract PWE-34 Figure 1 Predicting CSHF

(AUROC 0.556 and 0.603 respectively; *Abstract PWE34 Figure 1*).

Conclusions In these PLWH and elevated ALT, ~20% had CSHF and ~60% had HS. Lower HDL and diabetes were independent predictor of CSHF. Hazardous drinking or MS were identified in most patients with CSHF, however no risk factors were identified in almost 20%. This raises the intriguing possibility that CSHF may be caused directly by the HIV infection.

PWE-35 IMPROVED OUTCOMES FOLLOWING THE IMPLEMENTATION OF A DECOMPENSATED CIRRHOSIS DISCHARGE BUNDLE

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Introduction Decompensated cirrhosis is a complex disorder with a high mortality rate and as a result re-admissions to hospital are common following discharge. Our aim was to evaluate the impact of implementation of a 'Decompensated Cirrhosis Discharge Bundle (DCDB)' and determine whether this improves the provision of evidence-based care and reduces preventable readmissions.

Methods A baseline review of the management of consecutive patients discharged with a diagnosis of decompensated cirrhosis was conducted in 2017 to assess the management of complications including ascites, encephalopathy, varices and alcohol misuse, and to determine readmission rates. Subsequently the DCDB was developed and implemented. Two cycles of evaluation of the impact of the bundle were conducted, the first using a paper version (Nov 2018-Oct 2019) and the second an electronic version (Nov 2020-March 2021).

Results Overall, 225 patients (63% male; median age 55; median MELD 17; 72% alcohol-related) were reviewed. Clinical and demographic features were similar in the 3 review periods. The overall 30 day readmission rate was 30% (12% potentially avoidable) in baseline review (n=61) and areas for improvement were identified. In the first review following implementation of the DCDB (n=86) only 23 (27%) had a bundle completed. This increased to 69% (31/45) in the second review following implementation of the electronic DCDB. A comparison between patients with and without a DCDB is

Abstract PWE-35 Table 1

	DCDB n=54	No DCDB n=138	P value
Alcohol misuse	63%	64%	p=0.917
Alcohol team review	85%	66%	p=0.044
Thiamine prescribed	91%	85%	p=0.552
Community alcohol plan	62%	39%	p=0.026
HE related admission	30%	42%	p=0.138
Lactulose prescribed	94%	91%	p=1.0
Rifaximin prescribed	94%	84%	p=0.679
Ascites present	70%	69%	p=0.886
Discharge creatinine documented	66%	6%	p<0.001
Plan for U&Es check after discharge	61%	36%	p=0.012
Variceal bleed	15%	11%	p=1.0
Beta-blockers, repeat OGD planned or TIPSS	100%	89%	p=0.526
Readmissions within 30 days	31%	25%	p=0.470
Potentially preventable liver related 30-day readmission	4%	7%	p=0.407

shown in the table 1. Overall, use of the bundle was associated with improved care across all domains assessed.

Conclusions Implementation of a care bundle for patients with decompensated cirrhosis improved provision of evidence-based care at discharge. However, uptake of use of the bundle was slow but increased with an electronic version.

PWE-36 TEMPORAL CHANGES IN THE PREVALENCE OF GALLBLADDER DYSPLASIA AND ADENOCARCINOMA IN PATIENTS UNDERGOING CHOLECYSTECTOMY

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Introduction A metaplasia-dysplasia-carcinoma sequence is the most plausible carcinogenic pathway for gallbladder cancer and although the incidence of gallbladder carcinoma is increasing, little is known about its precancerous lesions. The aim of this study was to determine temporal changes in the prevalence of low-grade dysplasia (LGD), high-grade dysplasia (HGD) and gallbladder adenocarcinoma and associated risk factors.

Methods We retrospectively identified consecutive patients who underwent cholecystectomy between January 2011 and March 2020. Patients were grouped according to histology: no dysplasia; LGD; HGD; and adenocarcinoma. Fitted linear models estimated temporal trends in prevalence and mean age for all histological outcomes. Logistic regression estimated associated risk factors.

Results A total of 5 835 patients were included in the analysis. The prevalence of LGD was 1.47%, HGD 0.17% and adenocarcinoma 0.19%. Prevalence for all diseases increased over time, and mean age at diagnoses decreased over time. In a multivariate logistic regression model, with no dysplasia as the reference group, female sex increased the odds of LGD (OR 4.57, 95% CI 3.07-10.10, p=<0.0001). BMI was not associated with disease risk.