can be related to the effect of insulin resistance on hepatic cells and the associated fatty deposition inside the liver which lead to NAFLD as well as NASH.

We also explored the effect of antiviral treatment, mainly Tenofovir (TDF) and Entecavir (ETV), on the renal function of CHB patients with T2DM. Results showed a significant decrease in glomerular filtration rate (eGFR) after taking antiviral medication, with median eGFR of 89 ml/min/1.73m² (IQR=14) for TDF and 84 ml/min/1.73m² (IQR=19) for ETV, and latest median eGFR of 74 ml/min/1.73m² (IQR=19) for TDF, 70 ml/min/1.73m² for ETV (IQR=20). Results also showed a marked increase in serum creatinine levels as well for both groups pre and post-treatment with pre-treatment serum creatinine levels of 82 µmol/L (IQR=22) for TDF and 86 µmol/L (IQR=26) for ETV, and latest serum creatinine levels of 90 µmol/L for TDF (IQR=21) and 95 µmol/L for ETV (IQR=23). We then divided the levels of eGFR at different levels of HBA1C pre and post-treatment with TDF for clinical significance, it showed a marked decrease in levels of pGFR especially in prediabetic groups, with pre-treatment median eGFR of 82 ml/min/1.73m² to median eGFR of 64 ml/min/1.73m² for post-treatment results.

Another perspective that should be re-considered is the role of nurse-led virtual clinics in the management of chronic hepatitis B patients. Many liver services in the UK have started to adopt the concept of virtual clinics in the follow-up of chronic hepatitis B patients. Dietitian, as well as Diabetes experts, should be involved in the follow-up of overweight/obese patients with elevated ALT levels to prevent disease progression and its associated complications. Given the high number of patients with uncontrolled diabetes, consideration for re-choice of antiviral drugs should be considered given the diabetic nephropathy these patients may have as well as the adverse effect they can have from antiviral medications.

Clinicians should have a more active approach toward identifying and eliminating metabolic risk factors as well as cardiovascular risk in patients treated for chronic hepatitis B. Finally, comprehensive and longitudinal studies should be conducted for a better understanding of the extension of metabolic risk factors in our cohort and to accurately assess the associations between metabolic syndrome and chronic hepatitis B infection.

**References**


**PWE-39 A MULTIDISCIPLINARY APPROACH TO SYMPTOMATIC UMBILICAL HERNA IN PATIENTS WITH ESLD OPTIMISES OUTCOME**

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**Introduction**

Symptomatic umbilical hernias can occur in up to 20% of patients with cirrhosis and end-stage liver disease. Management remains controversial due to a paucity of data. We aimed to determine the outcome and the factors predicting mortality following repair of symptomatic umbilical hernias in this group of patients.

**Methods**

A retrospective review was performed for all patients with ESLD who presented to a specialist liver transplant centre with a symptomatic umbilical hernia requiring repair between 1998 and 2020. Overall survival was predicted using the Kaplan-Meier method, with censoring at transplantation. Logistic regression was used to determine predictors of 365-day mortality. Statistical significance set at p<0.05.

**Results**

111 patients with ESLD underwent hernia repair (emergency n=81, 73%). Median UKELD was 51 (40-63). Mortality at 30d and 365d was 4.5% and 9.9%, respectively. Prior to repair 28 patients (25%) were awaiting transplantation; 19 patients (17%) were transplanted during follow-up. Patients presenting as an emergency were more likely to have varices (13 v 0 p=0.018) and encaphalopathy (29 v 3 p=0.005). TIPS was performed in 29 patients (26%). Age, pre-operative bilirubin, sodium, creatinine, prothrombin time, albumin and UKELD were no different when comparing use of TIPS (p>0.05). 44 patients (40%) required ITU admission. Decompensation occurred in 44 patients (40%), with variceal bleeding in 13 patients (12%) and encaphalopathy in 33 patients (30%). Age>60 (HR 4.5 p=0.026) and ITU...
Introduction The joint BSG/BSH guidance on management of HH sets out clear criteria for the diagnosis and management of HH (Fitzsimons et al, 2018). Historically, patients with HH have been managed by both haematologists and gastroenterologists, mostly based on initial referral from primary care. Our aim was to assess adherence to the initial treatment pathway, and guidance on referral to gastroenterology.

Methods This was a retrospective study. A patient list was generated in June 2020 from patients with HH listed to attend Day Unit for regular venesection. Review of the electronic patient record was undertaken for each patient to obtain demographics, biochemical parameters at diagnosis, initial imaging, and subsequent management.

Results One hundred and twenty patient records were analysed. Seven records were excluded due to lack of data, leading to a final sample size of 113. Eighty were male, 33 were female with an average age of 59.3 (51.2 at diagnosis). Fifty-one percent of patients presented initially to haematology, with the remainder presenting to gastroenterology. Sixty-two percent of patients underwent weekly venesection and 70% had a target maintenance serum ferritin level of <50 mcg/L. Of the cohort presenting to haematology, 38% were not referred to gastroenterology despite meeting referral criteria. Of the 12 patients referred according to guidance, 5 underwent fibrosis assessment. Overall, 58 patients were identified who would have benefited from fibrosis assessment. Seventy-one percent of patients underwent ultrasound scans of the abdomen (with an average of 3 scans per patient) compared to 18 patients undergoing FibroScan.

Conclusions In general, adherence to the initial treatment pathway was variable — with the acknowledgement that in clinical practice, several factors lead to poor concordance with weekly venesection. Serum ferritin measurement was used to guide treatment in all cases. In all cases, upon confirming diagnosis, reference was made to ‘regular venesection’. Initial target ferritin was never, or very rarely, set as low as 20-30 mcg/L. The initial target in the Trust was set as less than 50mcg/L.

For patients presenting initially to haematology there was inconsistency in making referrals to gastroenterology. A proportion of this cohort would benefit from fibrosis assessment based on current guidance. The variable referral pattern to gastroenterology may have been due to lack of hepatology services in the Trust for a period of time. Furthermore, FibroScan services only became available in the Trust in 2020.

Ultrasound was overused and this may also be a reflection on previous lack of FibroScan services. We feel that patients would benefit from a defined HH service and closer coordination of care between specialists.