upon-Tyne NHS Foundation Trust, comparing the 12 months directly preceding the pandemic (YR1) to the first 12 months of it (YR2). Variables included; presentation, etiology, stage, treatment and SARS-CoV-2 infection.

Results New referrals with hepatocellular carcinoma (HCC) fell for the 1st time in 15 years in YR2 (35%; 125 in YR2 from 190 in YR1; Fig1A), with more presenting symptomatically. This was particularly striking for NAFLD patients (surveillance/incidental/symptomatic 32/55/13% in YR1 compared to 26/41/33% in YR2, $p=0.028$, Fig1B). Tumour size was greater in YR2 (med 44 vs 37 mm; $p=0.0165$, Fig1C), with 6 patients experiencing spontaneous hemorrhage in YR2. Despite challenges in YR2, patients received treatments appropriate for stage, in accordance with NHS waiting times. 11/125 (9%) acquired SARS-CoV-2. None of these patients died due to their SARS-CoV-2 infection. Cases presenting with intrahepatic cholangiocarcinoma were also reduced in YR2, but less so (64 vs 76), with the commonest mode of presentation unchanged (symptomatic ~75%).

Conclusion The tragic consequences of the SARS-CoV-2 pandemic are evident for patients in our region – whose cancers are now more commonly presenting symptomatically. In our series, 9% (11/125) of patients contracted SARS-CoV-2, of whom 3 subsequently died of advanced disease rather than SARS-CoV-2. At least 35% of our anticipated patients with HCC are ‘missing’. If routine activities, including HCC surveillance, are not re-instituted and patients encouraged to attend, it is likely that they too will present with symptomatic advanced HCC.

PWE-44 RESOURCE UTILISATION IN VARICEAL SURVEILLANCE PROGRAM DELIVERED WITHIN A NURSE-LED STABLE CIRRHOSIS CLINIC

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Introduction Bleeding from GOV represents 30% of total acute upper GI haemorrhage with mortality of up to 20% at initial presentation. Whilst mortality in Child A disease should be <10%, each emergency presentation is expensive. The GIRFT report recommends developing a database for cirrhosis in order to ensure a systematic approach to varices surveillance, something we have delivered via a Nurse led stable cirrhosis clinic since 2016. While BSG guidelines recommended screening for all patients with cirrhosis or PHT, we have adopted Baveno VI consensus workshop criteria ($TE < 20$ kPa or platelet count > 150) to safely avoid gastroscopy in this cohort. Grade 2/3 varices required primary prophylaxis with banding (VBL) or non-selective beta blockers (NSBB). In 2016, prophylaxis for grade 1 varices was not recommended.

Methods We conducted a retrospective review for all the cirrhotic patients seen in our nurse-led stable cirrhosis clinic during the first year of its establishment

Results In 2016, a total of 53(40 male) cirrhotic patients were reviewed in the clinic (ALD 25, NASH 9, other 20). Other aetiologies included HCV, PBC and HFE-related cirrhosis. Only 3 patients had Child Pugh B with the rest having Child A disease. No patient had ever suffered variceal bleeding. 26/53 (49%) patients met the exclusion criteria set by Baveno VI consensus and would have avoided OGD. 12/26 had their

index OGD which had been ordered prior to the instigation of the nurse-led clinic and reassuringly none showed varices. Screening was indicated for the remaining 27 patients. One patient passed away before his surveillance appointment. Grade I OV were diagnosed in 13/27 (48%) patients, of whom 7 inappropriately received NSBB and the remainder had follow up OGD at one year. Grade II varices were identified in 2/27 (7.5%) and band ligation performed. In the remaining 11/27 no varices were found and with annual improvements in fibroscan measurements only 5/11 required follow up OGD. None of the patients had variceal bleed in follow up 5 year period.

Conclusions Variceal screening is an important step in identifying high risk varices. By following Baveno VI criteria in this cohort, we have conformed the potential to reduce demand for OGD by around 50% for immediate OGD and another 50% of the remainder whose fibroscan results improve with abstinence from alcohol without subsequent bleeding events. Our review also shows an opportunity to improve resource utilisation by refreshing adherence to the existing guidelines.

PWE-45 BACTERAEMIA, SEPSIS, AND ANTIBIOTIC RESISTANCE IN AUSTRALIAN PATIENTS WITH CIRRHOSIS: A POPULATION-BASED STUDY

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Introduction Multiple factors predispose patients with cirrhosis to sepsis and/or bacteraemia and this has a high mortality rate. Within different geographic regions there are marked differences in the prevalence of infection with multidrug resistant organisms (MDRO). This study examined risk factors for and outcomes of sepsis/bacteraemia in Australian public hospital admissions with cirrhosis over the last decade, along with the bacterial pathogens responsible and their antibiotic susceptibility profiles.

Methods A population-based retrospective cohort study was conducted from 1 January 2008 to 31 December 2017. Hospital admissions for patients with a diagnosis of cirrhosis were categorized by the presence or absence of sepsis/bacteraemia. Clinical and socio-demographic information including cirrhosis aetiology, complications and comorbidities, and in-hospital mortality were examined using bivariate and multivariate analyses. In patients with bacteraemia, the type and prevalence of bacteria and antibiotic resistance was assessed.

Results Sepsis/bacteraemia was present in 3,951 of 103,165 hospital admissions with a diagnosis of cirrhosis. Factors associated with sepsis/bacteraemia included disease aetiology, particularly primary sclerosing cholangitis (adj-OR=15.09, 95%CI 12.24-18.60), alcohol (adj-OR=2.90, 95%CI 2.71-3.09), Charlson co-morbidity index ≥ 3 (adj-OR=3.54, 95%CI 3.19-3.93), and diabetes (adj-OR=1.87, 95%CI 1.74-2.01). Overall case-fatality rate among admissions with sepsis/bacteraemia was 27.7% (95%CI, 26.3%-29.1%) vs 3.0% (95%CI, 28.9%-31.1%) without sepsis/bacteraemia. Patients with sepsis/