Abstract PTH-47 Table 1 Use of blood products/vitamin K pre and post implementation of a trust proforma

		Pre proforma 08/17-08/19		Post proforma 01/21 onwards			
Liver biopsy		4		0			
Ascitic drain		38		4			
Total		42		4			
Test	Value	Cases with blood test result (data range)	Cases given appropriate prophylaxis*	Cases given prophylactic FFP	Cases with blood test result	Cases given appropriate prophylaxis	Cases given prophylactic FFP
Platelets $\times 10^9/L$	≤ 50	6 (18 to 42 $\times 10^9/L$)	2 (33%)		1	1 (100%)	
L	> 50	36			3		
	Not measured	0			0		
Fibrinogen g/L	≤ 1.2	8 (0.53 to 1.18 g/L)	0		1	0	
	> 1.2	32			1		
	Not measured	2			2		
PT seconds	> 16	39 (17 to 31 seconds)	4 (10%)	3 (8%)	4 (INR 1.5 in one case)	4 (100%)	1 (25%)
	≤ 16	1			0		
	Not measured	2			0		

*Platelets, cryoprecipitate or vitamin K

INR >1.2 or PT >16 . An online doctors survey was disseminated assessing knowledge of national guidelines. A trust proforma developed with input from local gastroenterology, haematology and interventional radiology services was implemented in January 2021.

Results The online survey (28 responses F1-registrar) identified 60% were unaware of national guidelines. 40% were not confident managing bleeding risk in liver disease, 33% felt FFP is useful prophylactically and 53% considered PT/INR as reliable predictors of bleeding risk.

Conclusion Clinician practice of the management of bleeding risk in liver disease patients undergoing AD/LB did not reflect national guidelines. Our intervention of a trust proforma shows promise in improving use of blood products. This project highlights the value of a collaborative approach to guideline development. The ongoing assessment of impact and review of the proforma by the multi-speciality steering group is recommended.

REFERENCE

1. Neuberger J, Patel J, Caldwell H, *et al* Guidelines on the use of liver biopsy in clinical practice from the British Society of Gastroenterology, the Royal College of Radiologists and the Royal College of Pathology *Gut* 2020;**69**:1382-1403

PTH-48 PATIENTS' PERSPECTIVES OF PALLIATIVE AND END-OF-LIFE CARE IN ADVANCED LIVER DISEASE: SYSTEMATIC REVIEW OF LITERATURE

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10.1136/gutjnl-2021-BSG.363

Introduction Liver disease, a major cause of death, worldwide affects younger people compared to other major causes of death. Though guidelines are emerging on what good end-of-

life (EOL) care in liver disease should look like, little appears to be known about patients' perspectives regarding palliative and EOL care, even though they are most affected by these guidelines.

Methods

Aim Explore current knowledge and understanding of patients' lived experiences, perspectives, and expectations in relation to palliative and EOL care in advanced liver disease.

Design Systematic review with thematic synthesis complying to the ENTREQ Statement.

Setting and participants Systematic search of databases (Ovid Medline and Web of Science) to identify qualitative studies, in English, exploring patients' perspectives of palliative and EOL care in advanced liver disease.

Abstract PTH-48 Table 1

1. The disease trajectory

- Unpredictability of course
- High rates of hospital admission as illness progresses
- Death in hospital

2.The distribution of services

- More in secondary care and hospital based
- Lack of coordinated care in the community

3.What do patients and carers want

- More care in the community

4.The disabilities from end-stage liver disease encompass a wide range

- Physical disabilities
- Consequences on day-to-day functioning
- Psychological distress
- Difficulties in advance care planning (ACP)

5.Barriers to discussing end-of-life care in end-stage liver disease

- Clinicians' reluctance to discuss palliative care
- Palliative care is perceived negatively

Results Only eight articles, amongst them involving 166 patients, met the study criteria. Themes demonstrated repeated hospital admissions towards the end of life, lack of coordinated care in community and barriers in discussion about palliative care in end stage liver disease due to lack of confidence amongst professionals and a negative view about palliative care amongst patients and carers. Emotional, financial and disability related needs of patients and their carers are often neglected. (Table 1)

Conclusions Further research into perspectives of patients with advanced liver disease and their carers regarding palliative and EOL care will help improve the implementation of patient-focussed palliative care, advance care planning and EOL care. Research should also be done into the barriers to EOL discussions so that they can be held earlier with the aim of improving patient and carer quality of life and outcomes. It would be interesting to see the comparison of the attitude to, and expectations from, palliative care among patients and their caregivers from different parts of the world where the aetiological spectrum of liver disease, the social construct of health-care and availability of palliative care differs significantly.

PTH-49 SUCCESSFUL ENDOSCOPY RECOVERY STRATEGY AFTER THE FIRST WAVE OF THE COVID-19 PANDEMIC

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10.1136/gutjnl-2021-BSG.364

Introduction Endoscopy other than essential or emergency cases was paused in March 2020 during the first wave of the Covid-19 pandemic leading to a significant backlog. In April 2020 the BSG issued new guidance for safe resumption of endoscopy services.

Methods We here described how we managed the endoscopy backlog generated by the first wave of the Covid-19 pandemic in a Covid-minimised unit. We evaluated the impact of service suspension on backlog, recovery strategy, infection control policy, results of pre-procedure Covid-19 testing, and 7/14-day post-procedure Covid-19 symptom screening.

Results 937 elective procedures were cancelled between 23 March and June 2020. A vetting tool linked to the booking system was used to categorise these as High-risk 2-week wait (n=57), Defer 3 months (n=439), Defer 6 months (n=300), Defer 12 months (n=9), Surveillance (n=45), Discharge back to referrer (n=87). Elective procedures restarted on 8 June 2020. Lists were initially booked with 50% reduction in volume compared to pre-Covid-19, to accommodate PPE, downtime and social distancing. We increased endoscopy administration from 2 to 5 staff, to implement 7-day pre-procedure 'SCOTS criteria' telephone screening, 3-day pre-procedure Covid-19 PCR testing, and 7/14-day post-procedure telephone follow-up. We introduced outpatient information leaflet and consent forms regarding Covid-19 risk. Inpatient endoscopy was carried out in the operating theatre until the end of August. On 17 July we removed downtime after lower GI endoscopy increasing capacity. Twice weekly evening lists resumed in August, with an extra evening list added in September. From 1 August until 10 October we used insourcing at weekend. We trialed outsourcing of 2 weekly lists for 4 weeks in August, but did not find this strategy effective. Additional Saturday and evening lists were performed by 6

endoscopists removed from the GIM rota. We were able to clear our waiting list by mid-October so that we could offer mutual aid to a neighboring hospital.

Between June and November we performed endoscopy in 3,481 outpatients. Each patient had pre-endoscopy Covid-19 swab and 20 (0.57%) were positive. 23 out of 3,261 (0.71%) patients developed Covid-19 symptoms after 7 days and 29 (0.89%) after 14 days.

Conclusions We demonstrated effective clearance of the endoscopy backlog in a Covid-19 safe environment over 4 months. Key interventions were advance vetting, increased administrative support, an endoscopy unit located in a separate building, quick implementation of infection control policies, insourcing and freeing of endoscopists from the GIM rota. Learning point was underestimating burnout of endoscopy nursing staff.

PTH-50 MICROSCOPIC COLITIS: MIND THE GAP

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10.1136/gutjnl-2021-BSG.365

Introduction Microscopic colitis (MC) is a chronic inflammatory disease that affects the colon. Characteristically it causes chronic, watery, non-bloody diarrhoea, which substantially reduces patient quality of life (QoL). MC may be less familiar than other causes of diarrhoea and could lead to delays in diagnosis of MC, or a failure to diagnose this condition.

Aims 1. To assess the timelines of referral, diagnosis and treatment in patients who are subsequently diagnosed with MC

2. To identify treatments initiated and potential culprit drugs in patients with MC

Methods Patients with MC were identified from electronic health records. Patient demographics including smoking status were gathered. Data was obtained on the date of symptom onset, clinical review, diagnosis and treatment intervention (advice on cessation of a potential culprit drug and/or start of treatment.)

Results 304 patients were diagnosed with MC, 230 females and 74 males (3.1:1). The median age of patients was 69 years (range 19-100). 42% of patients were current smokers, of which 54% did not receive smoking cessation advice. 219 patients (92%) were reviewed by a gastroenterologist post-symptom onset, with a median wait of 251 days (range 1-7516) from the time of symptom onset. Of those diagnosed with MC after symptoms, the median wait between symptom onset and diagnosis was 113.5 days (range 1-7286). 57 patients (25%) waited >1 year and 15 patients (7%) waited >5 years before diagnosis. For those initiated on treatment post-diagnosis, the median number of days from symptom onset to commencing treatment was 324 days (range 11-7516). 36 patients had treatment initiated prior to their diagnostic histology report. Most patients (58%) were given budesonide as their first treatment. 38% of patients required additional treatments, 17% required no treatment. Loperamide was given to 46% of patients receiving additional treatments. 67% of patients were taking a potential culprit drug, of these 20% were taking multiple potential culprit drugs (Omeprazole 19.9%, NSAID 18.7%, Lansoprazole 15.6%, Sertraline 8.10%, Beta blocker 6.54%). Of the patients taking a potential culprit drug, 52% were advised to stop the same drug and 4% were advised to stop a different drug.