absent drug levels were positive for HLA-DQA1*05 with Hazzard Ratio (HR) for development of anti-Infliximab antibodies of 4.54 (95% CI 1.73-11.89) and for antibodies with absent infliximab drug levels 9.86 (95% CI 2.43 -40.01). Higher proportion of HLA-DQA1*05 patients required dose escalation (78% vs 31%, $p=0.001$). After adjusting for age, initial infliximab dose and concomitant immunomodulator use, there was no difference anti TNF persistence in patients with HLA-DQA1*05 variant (HR 2.36, 95% CI 0.89-6.25, $p=0.06$).

Conclusions Determination of HLA-DQA1*05 status may identify patients at higher risk of anti-infliximab antibodies in ulcerative colitis. Early intervention with dose optimisation and concomitant immunomodulation may avoid loss of response and facilitate treatment persistence.

Liver

HWE-1 LONG-TERM OUTCOME FROM ALCOHOLIC HEPATITIS: SURVIVAL, READMISSION RATES AND ATTENDANCE AT OUT-PATIENT CLINICS

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Introduction Alcoholic hepatitis (AH) is recognised for its acute presentation and high short-term mortality. Relatively few studies have looked at the longer term outcome of AH patients, although achievement of abstinence from alcohol is associated with better survival. The aim of this study was to review the long-term outcome of patients with AH and in particular note their subsequent use of medical services.

Methods All patients recruited to the STOPAH trial from hospitals within NHS Greater Glasgow and Clyde (NHS GGC) were assessed. They were recruited between March 2011 and February 2014. Hospital admissions in the 2 years prior to admission were noted and for those who survived their STOPAH admission, subsequent gastroenterology/hepatology out-patient clinic (OPC) and in-patient episodes were recorded. Kaplan-Meier, Spearman's correlation and Odds Ratio analyses were undertaken: results are presented as medians and 95% confidence intervals. Censorship was until 1/10/2020 for survivors.

Results 140 patients were recruited to STOPAH from NHS GGC; with a median follow-up of 667 days (390 -1195) until censorship or death, survival was 22%. 108 (77%) survived their index STOPAH admission. 89 patients with no liver-related admissions in the 2 years prior to their index STOPAH admission had a hospital survival of 73%; the hospital survival of those with previous liver-related admissions was 84% ($p=0.16$). For 106 survivors of the index STOPAH admission for whom information was available, the median follow-up until censorship was 1261 days (823-1883). Their survival was 28%, with 20% survival for those with a prior liver-related admission and 34% for those with no such admission in the preceding 2 years ($p=0.057$). 92% of index admission survivors had a further hospital admission and of these 64% had a liver-related reason for first readmission. Median time to readmission after discharge was 101.5 days (56-161) and median number of subsequent admissions was

Abstract HWE-1 Figure 1

4.5 (4-5). 59% of readmitted patients did so prior to an OPC consultation. There were records of OPC appointments offered to 92 patients (87% of survivors): 79 patients attended at least one OPC appointment, the first being a median of 86 days (68-108) after discharge. The median attendance rate at OPCs was 70% (51-79%). Correspondence from the first OPC after index admission indicated no alcohol use in 56%, continued alcohol use in 24% and no record of alcohol intake in 20%. Those attending $\leq 50\%$ OPC appointments had a lower survival (19%) compared with those attending $>50\%$ (38%; $p=0.02$; Figure 1). There was a correlation between time to first OPC appointment and subsequent attendance rate with those attending sooner after discharge more likely to attend ($\rho = -0.367$; $p=0.0009$).

Conclusions With long-term follow-up, less than a quarter of patients with AH survive. Most patients were readmitted prior to an OPC consultation, but those who did attend $>50\%$ of offered OPCs had a better outcome. Documentation of alcohol use at OPC review was inadequate in a fifth of cases. Prompt and more assertive OPC follow-up might benefit this cohort of patients to improve long-term survival.

HWE-2 RECIDIVISM POST LIVER TRANSPLANTATION: A 7 YEAR FOLLOW UP

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Liver transplantation offers patients with end stage liver disease the prospect of significantly improved mortality and quality of life (Poynard et al., 1999). Alcohol related liver disease (ALD) has become a widely accepted indication for liver transplant, and outcomes compare favourably against transplant for non-alcohol related liver disease (Neuberger et al., 1997). However, concerns exist regarding the risk and implications of alcohol recidivism post-transplant (Neuberger et al., 1998).

The purpose of this study was to assess post-transplant outcomes of all patients transplanted for ALD since the inception of the Scottish Liver Transplant Unit, particularly identifying the rate and risk factors for recidivism within this cohort.

A retrospective case-note review was carried out of all patients transplanted between 1st November 1992 and 31st

October 2019 for ALD. Data was available for 409 patients. Demographic and socioeconomic data was collected, alongside pre-transplant psychiatric assessment. Evidence of recidivism in those surviving longer than 3 months post-transplant and subsequent outcomes were recorded.

1,761 patients underwent liver transplantation in Scotland over this 27 year period, 26.8% for ALD. Median follow up was 70 months (IQR 38-113) during which 319 patients remained abstinent, and 90 relapsed. Of these, 33 drank harmfully, and 3 developed ALD related graft loss.

Rates of recidivism were highest in those who at listing were; younger (55.6 vs 58.2 years $p=0.0006$), had a shorter pre-transplant abstinence (10 vs 15 months $p<0.0001$), no co-factor for liver disease ($p<0.0001$) and identified as high or moderate risk by psychiatry (59% vs 35% $p<0.0001$). Median time to recidivism was 21.4 months and this was not influenced by severity of drinking. Logistical regression identified several potential risk factors including; age (OR 0.959, [CI 0.922, 0.975]); presence of co-factor (OR 0.312, [CI 0.244, 0.604]); shorter pre-transplant abstinence (OR 0.953, [CI 0.944, 0.982]).

Here we present 27 years of follow-up data for all patients who underwent liver transplant for ALD related cirrhosis in Scotland, demonstrating a post-operative recidivism rate of 22%. Key factors that appear to increase risk of recidivism include younger age, absence of co-factor at listing, and shorter length of pre-transplant abstinence.

Oesophagus

HFR-1

CYTOSPONGE AS A RISK STRATIFICATION TOOL IN PATIENTS OVERDUE BARRETT'S SURVEILLANCE DUE TO COVID-19

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Introduction Endoscopic surveillance for Barrett's Oesophagus (BE) has been indefinitely postponed due to the COVID-19 pandemic (Rees Clin Med 2020). As well as the potential for missed progression to dysplasia, the negative impact on patients' quality of life is immeasurable.

The Cytosponge® is a minimally invasive cell sampling device which to date has been researched in screening for BE (Ross-Innes Lan Gastr Hep 2017). We describe the first worldwide use of the Cytosponge® outside a clinical trial to triage BE surveillance patients unable to undergo endoscopy due to COVID-19.

Methods Consecutive patients with non-dysplastic BE (NDBE) who were overdue endoscopy were invited to have the Cytosponge®. The sample was analysed for TFF3 (a marker of intestinal metaplasia), cellular atypia and p53. It was carried using minimal personal protective equipment (PPE) as it was not deemed to be an aerosol generating procedure (AGP).

Results 60 patients have undergone the Cytosponge® procedure to date. Most patients (58, 97%) swallowed the device and in 4 was a result not possible (2 - unable to swallow the Cytosponge®, 2 - sample not analysable/sponge did not enter stomach). No complications were encountered.

Abstract HFR-1 Table 1 Demographics, baseline Barrett's baseline information and outcome of all patients who have completed the Cytosponge® procedure. * 2 patients still awaiting endoscopic assessment. NDBE: Non-Dysplastic Barrett's Oesophagus, INDEF: Indefinite for dysplasia, LGD: Low-Grade Dysplasia, IMC: intramucosal adenocarcinoma

	TFF3: - Atypia: - P53: -	TFF3: + Atypia: - P53: -	TFF3: -/+ Atypia: + P53: -	TFF3: + Atypia: + P53: +
Number of patients	14	26	12	4
M:F	12 : 2	20 : 6	11 : 1	4 : 0
Median maximal BE length (cm)	2.5	5	5	6
Triage decision	Repeat Cytosponge®/ endoscopy within 24 months	Endoscopy in 12 months	Endoscopy within 3 months	Endoscopy within 3 months
Endoscopy and histology findings	-	-	NDBE: 5 ATYP: 1 INDEF: 2 LGD: 2	NDBE: 1 LGD: 2 IMC: 1

40 patients (71%) had a either a low-risk result (TFF3 positive only – 26) or required a repeat Cytosponge® (TFF3/aty-pia/p53 negative or equivocal – 14). 16 patients (29%) needed an endoscopy within 3 months (cellular atypia – 12, p53 & cellular atypia – 4). 14 of these patients have since had an endoscopy of which 7 had a new diagnosis of dysplasia (indefinite – 2, low grade dysplasia, LGD – 4, intramucosal adenocarcinoma, 1) (Table 1).

Conclusions The Cytosponge® has proved to be an acceptable non-endoscopic tool for patients with BE under surveillance where endoscopy is not possible. Preliminary data are promising to detect dysplasia and triage patients to endoscopy early. Further large scale, longitudinal follow-up is needed.

HFR-2

COMPUTER AIDED DIAGNOSIS FOR THE CHARACTERISATION OF DYSPLASIA IN BARRETT'S OESOPHAGUS WITH MAGNIFICATION ENDOSCOPY

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Introduction There have been significant advances in magnification endoscopic imaging of Barrett's oesophagus (BE). Magnification endoscopy of mucosal and vascular patterns arising in BE can help predict non-dysplastic from dysplastic mucosa. This can inform sampling and guide endoscopic eradication therapy. We aimed to develop a computer aided detection system that can support the diagnosis of BE dysplasia on magnification endoscopy.

Methods Videos were collected in high-definition magnification white light and virtual chromoendoscopy with i-scan (Pentax Hoya, Japan) imaging modes in patients with dysplastic lesions