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