Abstract OTH-1 Figure 1 (A) AIH v non-AIH CLD (B) AIH v non-CLD

eight (83%) of AIH patients were taking one or more immunosuppressive drug. There were no differences in rates of major outcomes between AIH and non-AIH CLD including hospitalisation (76% vs 85%; $p=0.06$), ICU admission (29% vs. 23%; $p=0.240$), and death (23% vs. 20%; $p=0.643$). Factors associated with death within the AIH cohort included age (OR 2.16/10 years; 1.07–3.81), Child-Turcotte-Pugh (CTP) class B (OR 42.48; 4.40–409.53), and CTP-C cirrhosis (OR 69.30; 2.83–1694.50), but not use of immunosuppression. Propensity score matched (PSM) analysis comparing AIH with non-AIH CLD demonstrated no increased risk adverse outcomes including death (+3.2%; -9.2%–15.7%) (Figure 1A). PSM analysis of AIH versus non-CLD patients ($n=769$) demonstrated increased risk of hospitalisation with AIH (+18.4%; 5.6–31.2%), but equivalent risk of all other outcomes including death (+3.2%; -9.1%–15.6%) (Figure. 1B).

Conclusion Despite immunosuppressive treatment, AIH patients were not at increased risk of adverse outcomes from COVID-19 compared to other causes of CLD and to matched cases without liver disease.

OTH-7 INTEGRATED CARE PLANS FOR ALCOHOL-RELATED HIGH IMPACT SERVICE USERS REDUCES HOSPITAL ATTENDANCES AND ADMISSIONS

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Introduction Alcohol-related hospital admissions have doubled in the last decade to > 1.3 m per year in England. Alcohol-related high impact users are a subgroup who have multiple hospital admissions or attendances related to alcohol during a short time-period. We aimed to determine the effectiveness of integrated care plans in improving outcomes of high intensity users and reducing resource use within our acute hospitals trust (NUTH).

Methods The multidisciplinary trustwide alcohol care team (ACT) agreed case management strategies for a cohort with the highest rates of alcohol-related admissions and/or ED attendances to NUTH. A comprehensive individualised care plan, drawing on several sources (acute hospital, community and addictions services) was agreed for each. This included details of keyworker contact details, a defined management plan, including threshold for admission, along with recommendations for involvement of safeguarding or statutory services, as appropriate. This care plan was then made available to staff in ED and Acute admissions, at the point of triage, along

with members of the ACT. Care plans, and the cohort of high impact users, were reviewed each six months.

Results Over 2 years, care plans were defined for 29 high impact users (15 male) with a median age 42 (36–84). In the 12 months prior to care plans, they had total 342 admissions to NUTH (mean 12 each) and an additional 521 ED attendances (mean 15 each). In the 12 months after introduction of care plans, they had 220 admissions to NUTH (mean 6 each) and a further 268 ED attendances (mean 8 each). Of this cohort, 9 (31%) died, mainly of alcohol-related causes, at median 12 (8–29) months after care plan implementation.

Conclusions The introduction of care plans for alcohol-related high impact has resulted in 36% less hospital admissions and 49% less ED attendances, within 12 months of their implementation. Despite strategic individualised care coordination, these high impact users continue to have a high risk of subsequent alcohol-related mortality. They require additional attention and ongoing specialist input.

OWE-3 TIMING OF PRE-EMPTIVE TIPS DOES NOT ALTER PATIENT OUTCOME, A UK MULTICENTRE STUDY

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Introduction International guidelines suggest consideration of pre-emptive transjugular intrahepatic portosystemic shunt (pTIPS) within 72h of endoscopic haemostasis following acute oesophageal variceal bleeding (OVV) in 'high-risk' patients. However, the 72h timeframe is arbitrary and pTIPS placement beyond 72h has never been explored. Large observational multicentre studies underscore continued equipoise regarding the value of pTIPS and, with the inclusion of a recent randomised control trial (RCT), highlight the difficulty in accessing timely interventional radiology to provide a non-emergency service in real-world clinical practice.

Methods Patients referred to 4 UK tertiary centres for pTIPS between 01/01/2010 – 31/12/2018 were included in the prospective data collection. The time to pTIPS from index endoscopy was recorded and pre-defined clinically relevant outcomes were observed relative to two groups, 'early-TIPS' (<72h) and 'late-TIPS' (72h – 30-days). Primary outcome was transplant free survival at 1-year. All patients were followed-up until 31/12/2020.