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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10.1136/gutjnl-2021-BSG.14

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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10.1136/gutjnl-2021-BSG.15

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.

Abstract OWE-3 Figure 1 Survival Analysis – Early vs Late TIPS

Results 180 patients were referred for pTIPS, across the 4 sites. 88 received 'early-TIPS' and 92 received 'late-TIPS'. Propensity score matching determined the early and late pTIPS groups were well matched with no difference in mean age (53 vs 52), predominant aetiology (alcohol liver disease; 61% vs 67%) mean MELD (16.42 vs 15.52), mean Child-Pugh Score (9.05 vs 8.9), mean portal pressure gradient (PPG) pre-TIPS (20.06 mmHg vs 21.58 mmHg) and mean PPG fall post-TIPS (14.67 mmHg vs 12.41 mmHg), respectively. There was no difference in patient outcomes between early and late pTIPS groups respectively; 1-year transplant free survival rate (69.3% vs 70.7%; $p=0.69$) (Figure 1), 1-year variceal rebleeding rates (6.8% vs 11.9%; $p=0.27$) and cause of death (liver failure; 27.3% vs 25%; $p=0.73$).

Conclusion Our study, which is the largest of pTIPS data to date, confirms placement of pTIPS within 72h offers no benefit to patient outcome over pTIPS placed between 72h – 30 days. Despite ongoing uncertainty as to whether pTIPS offers survival benefit over modern standards of care (i.e., band ligation and non-selective beta blockers), our results suggest pTIPS could become readily available given the potential easing of time constraints, however our findings should be considered in future RCTs.

OWE-4 NATIONAL AUDIT OF DIAGNOSIS, MANAGEMENT AND SURVEILLANCE IN PRIMARY SCLEROSING CHOLANGITIS IN THE UNITED KINGDOM

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10.1136/gutjnl-2021-BSG.16

Introduction Primary sclerosing cholangitis (PSC) is a rare disorder and as such clinical care can be heterogeneous. We audited PSC management across the UK against audit standards set by the British Society of Gastroenterology (BSG).

Method All UK PSC investigators were invited to complete an electronic questionnaire on the PSC patient cohort encompassing demographics, diagnosis, bowel and biliary tract cancer surveillance, and risk stratification data (March 2019 - Jan 2021).

Results 1,795 patients across 30 centres (liver units $n = 1548$, general gastroenterology units $n = 247$) were included. Median age at diagnosis was 51 years and 56.4% were men. Magnetic resonance cholangiography (MRCP) was performed as a

diagnostic investigation in 1616 patients (90.0%) and 777 (43.3%) had a liver biopsy. Most were monitored by a hepatologist ($n = 1610$, 89.7%). 931 patients (51.9%) received non-licensed therapy with Ursodeoxycholic acid.

785 patients (43.7%) had not undergone disease staging or risk stratification within the last 2 years; where performed, it was most commonly by transient elastography ($n = 645$, 78.7%). Surveillance for biliary tract cancer was not undertaken in 515 patients (28.7%); when performed, it was most commonly by ultrasound (US) ($n = 568$, 47.1%) or alternating MRCP/US ($n = 429$, $n = 35.6\%$). Ca 19 - 9 was utilised in 730 patients.

Concurrent IBD was present in 1264 patients (70.4%) with 256 (20.3%) having had a colectomy. Where classified, pancolitis (Montreal classification E3) was the commonest disease distribution (673/939, 71.7%) with 1.6% ($n = 15$) having isolated ileal disease. In those without IBD, 142 (28%) patients had not had a colonoscopy and biopsies to exclude diagnosis.

Among those with colitis without previous colectomy ($n=743$), 580 (78.1%) underwent annual colonoscopic surveillance; 30 (5.2%) with dye spray, 230 (39.7%) with biopsies and dye spray, and 252 (43.4%) with protocol biopsies alone. **Conclusion** There is unwarranted variation in the care of patients with PSC in the UK. In particular relating to risk stratification, exclusion of colitis and surveillance for biliary tract and colonic cancer. The lack of uniformity in clinical practice highlights the need for better education of clinicians about PSC management and the potential role of clinical networks for rare liver diseases within the UK.

OWE-5 CARVEDILOL VS. ENDOSCOPIC BAND LIGATION FOR VARICEAL BLEEDING SECONDARY PROPHYLAXIS; LONG-TERM RCT FOLLOW-UP

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10.1136/gutjnl-2021-BSG.17

Introduction Carvedilol reduces rates of variceal bleeding and rebleeding by lowering portal pressure. However, an associated pleiotropic survival benefit has been proposed. We aim to investigate further by undertaking long-term follow-up of a multicentre randomised control trial.

Methods The index study randomised 64 cirrhotic patients with clinically confirmed acute oesophageal variceal bleeding between June 2006 and December 2011 to receive either carvedilol or endoscopic band ligation (EBL).¹ We reviewed electronic patient records for all patients up to 31/04/2020 and updated the previously defined clinically relevant outcomes.

Results Of those randomised, 26 out of 33 participants received carvedilol in the follow-up period and 28 out of 31 attended for regular EBL sessions. There were no significant differences in baseline characteristics between groups. Mean follow-up for all participants was 2217 days. The mean duration of carvedilol administration was 1267 days. On intention to treat analysis, there was a trend towards improved survival in the carvedilol group, but this did not reach statistical significance ($p=0.09$). However, on per-protocol analysis, carvedilol administration was significantly associated with improved long-term survival ($p<0.01$), as well as fewer liver related deaths (4% vs 29%, $p=0.02$, OR=0.1) and fewer participants