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

¹Evangelia Fatourou*, ²Sarah Hyde, ³Sarah Hyde, ⁴Martine Walmsley, ¹Graeme Alexander, ²Simon Rushbrook, ³Palak Trivedi, ¹Douglas Thorburn, Contributing Investigators UK PSC. ¹Sheila Sherlock Liver Centre and UCL Institute for Liver and Digestive Health, Royal Free Hospital, London, UK; ²Department of Hepatology, Norwich Medical School, University of East Anglia, Norwich, UK; ³University Hospitals Birmingham, Birmingham, UK; ⁴PSC Support, Oxford, UK

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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

¹Philip Dunne*, ²Peter Hayes, ³Dhiraj Tripathi, ⁴Joanna Leithead, ¹Lyn Smith, ¹Dan Gaya, ¹Ewan Forrest, ¹Adrian Stanley. ¹Glasgow Royal Infirmary, Glasgow, UK; ²Royal Infirmary of Edinburgh, Edinburgh, UK; ³Queen Elizabeth Hospital, Birmingham, UK; ⁴Forth Valley Royal Hospital, Sterling, UK

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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

experiencing a hospital admission with decompensated liver disease (11% vs 50%, $p < 0.01$, OR=0.13) compared to the EBL group, respectively. There were no statistically significant differences in other adverse outcomes between carvedilol and EBL groups, including variceal rebleeding (39% vs 32%, $p = 0.78$, OR=1.3).

Conclusion Following an acute variceal bleed in cirrhotic patients, carvedilol is associated with survival benefit and fewer hospital admissions. Further studies are needed to validate this finding and explore the potential benefit in other patient groups.

REFERENCE

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OWE-6 MULTICENTRE EVALUATION OF SECOND LINE THERAPIES IN PRIMARY BILIARY CHOLANGITIS: UK EXPERIENCE

^{1,2,3}Nadir Abbas*, ⁴Emma Culver, ⁵Douglas Thorburn, ⁵Neil Halliday, ⁶Hannah Crothers, ^{7,8}Jessica K Dyson, ^{7,8}April Phaw, ⁹Richard Aspinall, ¹⁰Salim I Khakoo, ¹¹Yiannis Kallis, ¹²Belinda Smith, ¹³Imran Patanwala, ¹⁴Anne McCune, ¹⁵Vinod Hegade, ¹⁵Chenchu R Chimakurthi, ¹⁵Rebecca Jones, ⁴Michael Orrell, ¹⁶George Mells, ^{7,8}David Jones, ¹⁷Gideon Hirschfield, ^{1,2,3}Palak J Trivedi. ¹NIHR Birmingham Biomedical Research unit, Centre for Liver and Gastroenterology Research, University of Birmingham, Birmingham, UK; ²Institute of Immunology and Immunotherapy, University of Birmingham, Birmingham, UK; ³The Liver unit, Queen Elizabeth hospital, Birmingham, UK; ⁴Oxford Liver Unit, John Radcliffe Hospital, Oxford, UK; ⁵Institute of Liver and Digestive Health, University College London, London, UK; ⁶Department of Informatics, University Hospitals Birmingham, Birmingham, UK; ⁷Department of Hepatology, Newcastle upon Tyne Hospital NHS Foundation trust, Newcastle, UK; ⁸NIHR Newcastle Biomedical Research Centre, Newcastle University, Newcastle, UK; ⁹Department of Gastroenterology and Hepatology, Queen Alexandra Hospital, Portsmouth, UK; ¹⁰Clinical and Experimental Sciences, Faculty of Medicine, University of Southampton, Southampton, UK; ¹¹Department of Hepatology, Barts Health NHS Trust and Blizard Institute, Queen Mary University of London, London, UK; ¹²Department of Digestive Diseases, St Mary's Hospital, Imperial College London, London, UK; ¹³Department of Gastroenterology and Hepatology, Royal Liverpool and Broadgreen University Hospitals NHS trust, Liverpool, UK; ¹⁴Department of Liver Medicine, University Hospitals Bristol NHS foundation Trust, Bristol, UK; ¹⁵Department of Hepatology, Leeds Teaching hospital NHS trust, Leeds, UK; ¹⁶Academic Department of Medical Genetics, University of Cambridge, Cambridge, UK; ¹⁷Toronto Centre for Liver Disease, University of Toronto and University Health Network, Toronto, Canada

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Introduction Our aim was to compare the effectiveness of second-line therapies in primary biliary cholangitis (PBC), with regards Obeticholic acid (OCA) and non-licensed therapy (fibrates; FA) across a nationwide cohort of patients (pts).

Method Efficacy and safety data was accrued from 12 centres across the UK. Biochemical parameters are presented relative to the upper limit of normal (ULN).

Results Between August 2017-March 2020 we captured data from 457 PBC pts who initiated second-line therapy ($n = 349$ OCA, 48 bezafibrate, 60 fenofibrate). The OCA group manifest greater ALP values at baseline than those initiating FA therapy ($2.9 \text{ v } 2.3 \times \text{ULN}$; $P = 0.001$), with a greater proportion being ursodeoxycholic acid non-responders (63.5% vs 45.4%; $P = 0.001$), cirrhotic (16.5% v 8.3%; $p = 0.03$), or having an abnormal bilirubin (22.1% v 12%; $p = 0.02$). At 12mo, the magnitude of ALP reduction was 29.3% and 56.7% in the OCA and FA groups ($p < 0.001$ between groups), with 2% and 49% of pts attaining normal ALP values (Figure 1). By contrast, 50.8% and 28.1% attained a normal ALT at 12mo (Figure 1). Moreover, 37.3% of the OCA group who had an abnormal bilirubin at baseline normalised values at 12mo ($p < 0.05$) - bilirubin values did not change significantly in the FA group. 12mo biochemical response rates (Paris criteria) were 71.1% and 83.1% under OCA and FA therapy, respectively ($p = 0.141$ between groups). In patients with cirrhosis under OCA treatment ($n=57$), significant reduction in ALP, ALT and bilirubin were observed at 12 mo ($p < 0.05$ for all comparisons), with 61.5% attaining full biochemical response. The number of patients with an elevated bilirubin and/or cirrhosis in the FA group was too small to permit subgroup analysis therein. Escalation in anti-pruritus therapy was observed in 26.1% and 23.2% of pts ($P = \text{n.s.}$). Mild-moderate elevations in liver biochemistry (DILIN classification) were reported in 4.6% and 12.0% of pts under OCA and FA therapy ($p < 0.05$).

Conclusion In this non-randomised study, the magnitude of ALP reduction was greater with FA derivatives, whereas rates of ALT and bilirubin normalisation were more pronounced under OCA. The need for anti-pruritus treatment is similar between groups, although putative rates of drug-induced liver injury appear greater under FA therapy.

Abstract OWE-6 Figure 1