

Abstract P39 Table 1

	UDCA+BZF	UDCA+OCA+BZF	BZF
Median age starting BZF	53.5 (39-72)	60 (53-68)	66.5(56-74)
Median liver stiffness (Fibrosis score kPa)	8.25 (3.3-46.2)	10.5 (5.1-13.5)	12.8 (8.2-27.3)
Total number of patients started on therapy	14	5	4
Co-existing liver disease	2 (14)	0 (0)	1 (25)
Tried OCA for at least 12 months prior (%)	8 (57)	5 (100)	0 (0)
Total number of patients with >15% reduction in ALP (%)	10 (71)	5 (100)	3 (75)
Total number of patients with ALP>1xULN to ALP<1.67xULN (%)	5 (36)	4 (80)	2 (50)
Total number of patients who normalised ALP (%)	2 (14)	1 (20)	1 (25)
Median% reduction in ALP between months 1-3 of starting BZF	45.6(7.5-72.9)	52.9 (25.2-63.1)	27.2 (11.1-73.9)
Total number of patients stopped therapy due to intolerance/side effects (%)	2 (14)	0	1 (25)

Ursodeoxycholic acid (UDCA) is first line therapy and Obeticholic acid (OCA) is second line therapy for those intolerant or unresponsive to UDCA. Bezafibrate (BZF) is an unlicensed therapy available for those intolerant or unresponsive to UDCA or OCA. The aim of this analysis is to investigate effectiveness and safety of BZF in a real world, specialist centre setting.

All patients dispensed BZF from July 2019 to June 2020 from Royal Free London Hospital were included. Using dispensing and clinical records, demographic, pharmacological and clinical data were collated.

24 patients were treated with BZF. 1 patient was excluded due to being treated with plasma exchange making her laboratory data uninterpretable. All patients were female with a median age of 56 years and as a group, had elevated median liver stiffness of 10.2kPa. The table 1 below shows the relevant outcomes. Biochemical response is presented in groups treated with BZF and UDCA, combination of BZF, OCA and UDCA or BZF alone.

Our data demonstrate that over a median of 2 months follow-up, BZF is well tolerated with only 3/23(13%) stopping therapy. BZF was effective especially used as triple therapy, as shown by at least 15% reduction in ALP in 18/23(78%) and ALP<1.67xULN in 15/23(65%) even at this very early time point. No patients died or experienced complications of hepatic decompensation.

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VIDEO CLINICS VERSUS STANDARD FACE-TO-FACE APPOINTMENTS FOR LIVER TRANSPLANT PATIENTS IN ROUTINE HOSPITAL CARE: A FEASIBILITY RANDOMISED CONTROLLED TRIAL OF MYVIDEOCLINIC

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Introduction There has recently been a rapid increase in the number of health and social care organisations offering remote consultations in order to minimise the spread of disease following the outbreak of COVID-19, but their effectiveness is unclear. The majority of studies focusing on remote consultations to date have evaluated telephone appointments. Although some studies have used video conferencing technology in the secondary care sector, the sample sizes have been small and they differ in their findings. This study evaluated the

feasibility of implementing video clinics at a large hospital trust in the UK and assessed whether the intervention improved patient satisfaction compared to standard face-to-face appointments for liver transplant patients.

Methods Clinically stable liver transplant patients were randomised to video clinic appointments (intervention) or standard face-to-face appointments (usual care). The intervention group had routine follow-up appointments via secure video link. Participants were asked to complete post-appointment questionnaires over 12 months. The primary outcome was the difference in scores between baseline and study end by patient group for three domains of patient satisfaction using the Visit-Specific Satisfaction Instrument (VSQ-9). An embedded qualitative process evaluation used interviews to assess patient and staff experiences.

Results Fifty four patients were randomised: 29 to receive video clinics and 25 to usual care (recruitment rate 26.6%). Crossover from intervention to usual care was high (44.8%). 129 appointments were completed with 64% of questionnaires returned. Patient satisfaction (intention-to-treat analysis) increased in both intervention and usual care groups but the between-group difference was not significant after controlling for baseline scores. Video appointments were perceived to save patients time and money, and patients found video clinics to be less burdensome, with fewer negative impacts on their health. Technical problems with the software were common, however, the software is constantly evolving and as time goes on these types of problems should ease. Both clinicians and patients saw video clinic appointments as positive and beneficial.

Discussion The UK National Health Service is facing huge challenges with regards to staffing, budgets and space due to increasing patient numbers. Being innovative by using available technology to offer routine follow-up appointments via secure video link may help ease some of the burdens and free up clinic space for those patients who need to be seen face-to-face. This study outlines our experiences of using a remote video consultation system and the associated advantages and pitfalls.

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IDENTIFYING ANTI-MITOCHONDRIAL ANTIBODY (AMA) POSITIVE PREVALENCE: AN UNDIAGNOSED DISEASE IN NORTH YORKSHIRE

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Introduction Primary Biliary Cholangitis (PBC) is a chronic, progressive disorder, with a relatively well-tolerated treatment

option in the form of Ursodeoxycholic acid. A confident diagnosis of PBC relies upon a positive anti-mitochondrial antibody (AMA), a raised alkaline phosphatase (ALP) and/or immunoglobulin M (IgM). York Teaching Hospitals NHS Foundation Trust (YTHT) serves a population of 800,000¹, however our existing PBC database included only 100 patients. Given the prevalence (35 per 100,000²) it is likely there are a significant number of undiagnosed cases within our population.

Aim To review historical positive AMA tests throughout YTHT, with the aim of identifying patients with hitherto undiagnosed PBC.

Method An IT-based search identified all positive AMA blood tests over a nine year period (2009–2018) (n = 731). An electronic note review of a proportion (n = 204) established demographic details, blood test results (including liver blood tests and immunoglobulins), the department requesting the test and consequential action taken.

Results Data from 2017–18 revealed 204 patients with a positive AMA, 88% of whom were female. Tests were predominantly requested by specialties other than hepatology; secondary care specialties (52%) GPs (38%) and hepatologists (9%). 34% had a known diagnosis of PBC.

31% of the cohort had a raised ALP (ALP >130 IU/L). Of those patients in whom immunoglobulins were performed (n = 112) over half, 57%, had a positive IgM. 115 patients (56%) had a positive AMA only, of these hepatology advice was sought in less than half (44%) of cases. 19 patients (9%) had results in keeping with a diagnosis of PBC, but were not referred, or previously known to, the hepatology service.

Discussion Our results have identified a significant number of patients in this population with undiagnosed PBC who could benefit from treatment. Identifying patients who potentially have established PBC is relatively non-invasive, and form part of the panel of blood tests frequently requested in primary and secondary care. As many such patients do not end up with either a formal diagnosis or appropriate referral, perhaps it is time to recommend all hospitals interrogate their laboratory databases in this way.

REFERENCE

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2. Hirschfield GM, Dyson JK, Alexander GJM, et al. The British Society of Gastroenterology/UK-PBC primary biliary cholangitis treatment and management guidelines. *Gut* 2018;**67**:1568–1594

P42

IMPROVING QUALITY IN LIVER SERVICES (IQILS) KEY PERFORMANCE INDICATORS AUDIT – AN OPPORTUNITY TO IMPLEMENT CHANGE AND IMPROVE PATIENT CARE

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Introduction The North Bristol Liver Unit (NBLU) 2018–2019 audit against the Improving Quality in Liver Services (IQILS) Key Performance Indicators (KPI) demonstrated good compliance but identified service improvement opportunities (table 1). The unit introduced twice daily AMU in-reach service, and improved the junior doctor training programme. We present re-audit after these service changes.

Methods Patients with decompensated liver disease admitted to the gastroenterology ward between 01/08/2019 to 31/01/2020 were retrospectively identified. Electronic clinical records were interrogated to audit practice against the KPI recommending early specialist review, diagnostic ascitic tap in patients with ascites, administration of antibiotics in spontaneous bacterial peritonitis (SBP) and acute variceal bleeding.

Results Over 6 months, 111 admissions were identified [67% male; mean age 55 years (range 31–88)] with most common aetiology being alcohol (81%) and NAFLD (12%).

85/92 (92.3%) patients (excluding admissions to other specialities etc.) received specialist review within 24 hours of admission (table 1). Diagnostic paracentesis was attempted in 53 patients (92.9%) with clinically significant ascites. All 4 patients (100%) with confirmed SBP received antibiotics and albumin within 12 hours of diagnosis. 19/20 (95%) and 11/12 (92%) patient with suspected and confirmed variceal bleeding respectively received prophylactic antibiotics.

Discussion The North Bristol Liver Unit achieved over 90% compliance in all areas of IQILS KPI after implementing service improvement changes as a result of previous IQILS audit. This example emphasises the importance of critical self-assessment and engaging with national strategies to improve the care of patients with chronic liver disease.

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Key Performance Indicators	Year 1 (2018-2019)	Year 2 (2019-2020)
Specialist review within 24 hours of admission	82.3%	92%
Diagnostic paracentesis	90.5%	92.9%
Antibiotics in patients with SBP	100%	100%
Albumin in patients with SBP	70%	100%
Prophylactic antibiotics in variceal bleed	90.9%	95%