

**P32** **EARLY ANASTOMOTIC BILIARY STRICTURES FOLLOWING ORTHOTOPIC LIVER TRANSPLANTATION CAN BE SUCCESSFULLY TREATED USING ENDOSCOPICALLY PLACED SELF-EXPANDING METAL STENTS**

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**Introduction** Anastomotic biliary strictures (ABS) have been reported in approximately 13% of patients undergoing orthotopic liver transplantation (OLT). Without treatment these can lead to progressive graft failure. Endoscopic management of these strictures with temporary fully covered self-expanding metal stents (SEMS) offers a non-surgical option for their management. This retrospective case series describes the outcomes of ABS managed using SEMS at our centre. Unit standard practice is to reserve endoscopic management for early ABS and undertake a biliary sphincterotomy to reduce pancreatitis risk.

**Methods** The electronic records of all patients who underwent both OLT and endoscopic retrograde cholangiopancreatography (ERCP) between January 2013 and March 2020 were reviewed. Patients were selected from this group if they were found to have an ABS as diagnosed by biochemical liver function test derangement and corresponding characteristic radiological findings. Demographic data, technical aspects of the procedure, success rate, and complications were recorded.

**Results** A total of 36 transplant recipients were diagnosed with ABS. This group underwent a total of 45 ERCP procedures. The median time from transplant to ABS diagnosis was 6 months (interquartile range (IQR) 2 – 22 months). There was a balloon dilatation prior to stent placement in 13 procedures (29%). There was a sphincterotomy either at the time of stent placement or during a preceding procedure in 33 cases (92%). There were ten cases of pancreatitis (22%), four cases of cholangitis (9%) and two of bile leak (4%). There were eight cases of pancreatitis in the group of 33 who had undergone sphincterotomy (24%) and two cases of pancreatitis in the group of three who had not (67%). There was one case of bleeding following sphincterotomy (3%) that occurred immediately and did not require transfusion. The median time to stent removal was 105 days (IQR 67 – 125). Only one case (3%) required surgical biliary reconstruction. The avoidance of the need for biliary reconstruction was regarded as the key outcome for successful endoscopic management of ABS and this was achieved in 35 cases (97%).

**Conclusion** Early ABS following OLT were effectively managed using endoscopically placed biliary stents in the majority of cases. The rate of pancreatitis was lower in the sphincterotomy group. These data support the practice of temporary SEMS placement for early ABS and sphincterotomy to reduce pancreatitis risk.

**P33** **REAL- WORLD DATA FROM A TERTIARY LIVER CENTRE FOR PATIENTS WITH CHRONIC LIVER DISEASE RECEIVING PALLIATIVE CARE**

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Despite the increasing number of patients dying from chronic liver disease (CLD) globally, involvement of palliative services remains a distinct challenge in this cohort.

This study evaluated the level of palliative care CLD patients, managed in a tertiary liver centre, received.

Data was collected retrospectively for patients who died in hospital between May 2015–2018. A list was obtained from the coding department and filtered to identify only the patients that died during their admission. The clinical notes for each patient were scrutinised using the hospital's electronic database.

Only patients with CLD who had regular follow up at the centre were included in the study.

Patients that were admitted to an intensive care unit, listed for liver transplant, referred from another trust, first presentation CLD, not previously known to the hospital, admitted for pre-transplant assessment, or where cause of death was unrelated to CLD, were excluded from the study.

3003 CLD patients required 6088 admissions between May 2015–2018. There were 350 deaths. 28 patients were identified following application of the inclusion criteria. The patients had an average of six unplanned hospital visits in the last 12 months of life. The average length of their last admission was 18 days. Patients were referred to the palliative care team an average of six days prior to death and an average of 10 days after admission.

29% were referred to the palliative care team prior to their last admission (Mean = 3 months). Palliative medications were prescribed an average of three days prior to death. 7% had no palliative medications prescribed prior to death. 46% did not have non-essential medications stopped prior to death. 36% continued to have active observations up to death. All patients received regular mouth care.

This study has highlighted that most CLD patients receive minimal palliative therapy until the last days of life. CLD runs a protracted, unpredictable course but an increased frequency of hospital admissions appears to be a good indicator of disease terminality.

Predicting reversibility of decompensation in CLD is challenging even for experienced clinicians. As a result, most clinicians remain reluctant to offer palliation until the last days of life.

Earlier engagement with palliative care would help patients and relatives accept their prognosis and establish treatment limits. It is unlikely to reduce the number of hospital admissions; however, it is more likely to help patients attain better symptom control and avoid unnecessary medical treatment.

**P34** **WITH 30% OF THE POPULATION OF HULL EITHER BINGE DRINKING OR DRINKING ABOVE THE CHIEF MEDICAL OFFICERS GUIDELINES, 12.6% OF THESE DRINK TO HARMFUL LEVELS. ALCOHOL SPECIFIC MORTALITY RATES WITH THE CITY ARE 21% HIGHER THAN THE NATIONAL AVERAGE, WITH AN AVERAGE AMBULANCE CALL OUT RATE OF 203 PER MONTH FOR ALCOHOL RELATED ILLNESS/INJURIES. CAN A DEDICATED ALCOHOL CARE TEAM POSITIVELY IMPACT HULL'S GROWING ALCOHOL PROBLEM?**

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The Alcohol Care Team launched on January 1st 2020 and was tasked with developing a service to reduce hospital