patients were on a PPI for >1 year. The table 1 below highlights those patients prescribed a PPI and the presence of side effects associated long term PPI use.

During the admission 8 patients were deescalated off their PPI by the hepatology pharmacist and 8 were newly started on a PPI, 3 of whom had a clear indication; resulting in 58% of patients being discharged on a PPI.

Conclusions The use of PPIs in decompensated cirrhotic patients without a clear indication is demonstrated as an issue in a tertiary hepatology centre. Over 70% of patients with a history of HE or SBP are presently prescribed a PPI, with a lower prevalence in those patients without HE or SPB. Hepatology pharmacists are well placed to review PPI prescribing and initiate a de-escalation process.

P218 THE MANAGEMENT OF PRIMARY BILIARY CHOLANGITIS (PBC) ACROSS UK HOSPITALS: DOES CARE DIFFER?

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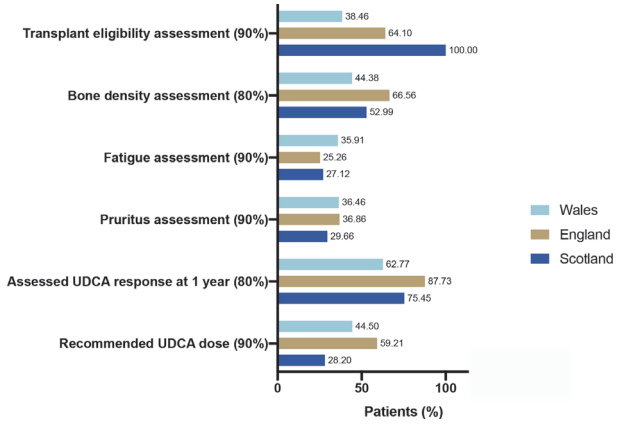
10.1136/gutjnl-2020-bsgcampus.293

Introduction Primary Biliary Cholangitis (PBC) is a progressive, autoimmune, cholestatic liver disease affecting approximately 15,000 individuals in the UK. Updated guidelines for the management of PBC were published by The European Association for the Study of the Liver (EASL) in 2017. We report on the first multicentre, national audit which assesses the quality of care and adherence to guidelines.

Methods A retrospective audit of all adult patients with PBC was undertaken in 11 NHS trusts in England, Wales and Scotland between January 2017 and March 2020. Data on patient demographics, ursodeoxycholic acid (UCDA) dosing and key guideline recommendations was captured from medical records. Results from each trust were evaluated against national guidelines for target achievement and analysed using Chi-square analysis for variation in guideline adherence between trusts.

Results A total of 790 patients with a diagnosis of PBC were identified across 11 national health trusts. The mean age was 62.1 years (SD, 13.16) and the cohort was predominantly female (94.2%). The data demonstrated that the majority of trusts did not meet all of the recommended EASL standards, set at 80% or 90%. There were significant variations in the following standards across the trusts: optimal prescription of UDCA (range: 15.8% - 88.8%) and assessment of biochemical response at one year (range: 53.3% - 100%), assessment of bone density (range: 22.2% - 77.4%), assessment of clinical symptoms (pruritus and fatigue) (range: 12.2% - 80%) (all $p<0.0001$), and assessment of transplant eligibility in high-risk patients (range: 0% - 100%) ($p=0.0297$). When comparing countries, significant variation in performance was observed between England, Wales and Scotland (figure 1). Tertiary centres were found to perform significantly better than secondary centres.



Abstract 218 Figure 1 Comparison of PBC care between the studied trusts in England, Wales, Scotland

Conclusions This is the first UK-wide PBC audit that provides a unique insight into the care received by PBC patients across the UK. Our findings identify a gap in the care of patients with PBC and suggest the need for an intervention to improve guideline adherence. This has important implications in improving symptom control, preventing end stage liver disease and accessing novel therapies. These findings have been used to develop a PBC Review tool and we recommend its incorporation into clinical practice. As the first audit of its kind, it will be refined for a wide-scale re-audit.

P219 NON-CIRRHOTIC, NON-MALIGNANT ACUTE PORTAL VEIN THROMBOSIS – SHOULD WE BE DOING MORE?

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10.1136/gutjnl-2020-bsgcampus.294

Introduction For cases of non-cirrhotic, non-malignant acute portal vein thrombosis (aPVT) guidance (European Association for the Study of the Liver Clinical Practice Guidelines: vascular diseases of the liver. *J Hepatol*ogy, 2016) advises treatment with low molecular weight heparin (LMWH), screening for prothrombotic conditions, anticoagulation for at least 6 months and repeat CT imaging at 6–12 months to assess recanalisation. Thrombolysis and/or interventional radiology may also be considered in the acute management.

We audited the management of these cases in our centre to inform the development of an aPVT treatment pathway.

Methods A retrospective search of PACS was done for inpatient CT scans from 2013–2018 where the report contained any of: 'portal vein thrombosis', 'mesenteric vein thrombosis', 'portomesenteric vein thrombosis' or acronyms: 'PVT', 'SMVT', 'PMVT'.

Cases of chronic PVT, cirrhosis or malignancy were excluded. Electronic notes were examined to identify underlying aetiology at diagnosis and how the aPVT was managed.

Results 98 cases of aPVT were identified over the 5-year period. 35 were excluded due to malignancy (22) and cirrhosis (13).

The remaining 63 cases were true non-cirrhotic, non-malignant aPVT. Pancreatitis was the commonest aetiology (32%) followed by intra-abdominal infection (24%), post abdominal surgery (19%), unprovoked (16%) and other (9%).

9 patients died before discharge and a further 3 died within 6 months of diagnosis. None underwent thrombolysis or interventional radiology treatment. Only 21% (n=13) had evidence of a thrombophilia screen.

59% (n=37) of cases were anticoagulated of which 50% had LMWH with bridging to warfarin, 44% LWMH only and