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?

[1,2]Mathuri Sivakumar*, [2]Akash Gandhi, [1,2]Laith Al-Rubaiy, [3,4]David Jones. *[1]Imperial College London, UK; [2]Northwick Park Hospital, London, UK; [3]Newcastle University, UK; [4]Newcastle Hospitals NHS Foundation Trust, UK*

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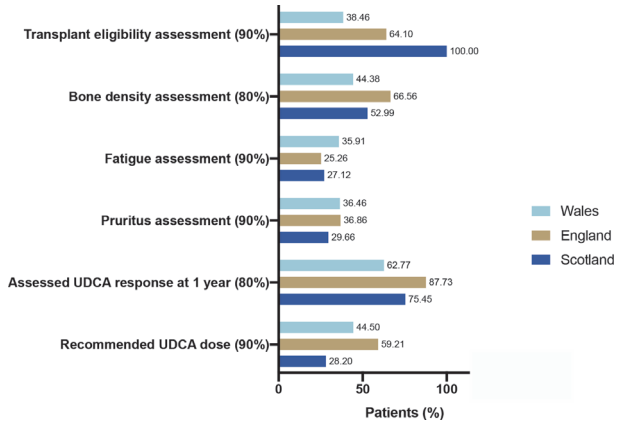
Introduction Primary Biliary Cholangitis (PBC) is a progressive, autoimmune, cholestatic liver disease affecting approximately 15,000 individuals in the UK. Updated guidelines for the management of PBC were published by The European Association for the Study of the Liver (EASL) in 2017. We report on 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?

Alexander Smith*, Charlotte Rutter, Janisha Patel, Mahshad Mousavi. *University Hospital Southampton, Southampton, UK*

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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

6% rivaroxaban. Duration of anticoagulation could be ascertained in 28 patients: 43% had 6 months, 39% lifelong, 7% had 4 months and the other 3 cases separately had 6 weeks, 2 months and 12 months.

Of the 51 patients who survived >6 months after diagnosis 59% had repeat CT imaging. The majority (n=23) were anticoagulated and there was recanalisation in 61%, partial recanalisation in 13% and cavernous transformation in 26%. 83% of those with cavernous transformation had portal hypertension.

6 of the non-anticoagulated cases had a repeat CT. 1 had partial recanalisation and had developed varices. The other 5 had recanalisation but notably these cases were non-occlusive aPVT.

Conclusions This audit highlighted inconsistencies in the management of non-cirrhotic, non-malignant aPVT in our centre. On assessment of recanalisation several cases had cavernous transformation and resultant portal hypertension but many did not get this assessment and so their risk of portal hypertension is unknown.

As a result of these findings we are developing an aPVT pathway to guide clinicians, minimise complications of aPVT and develop a consistent approach in our trust.

P220 FAILURE TO PERFORM REPEAT ASCITIC TAP AT 48HR HAS POORER OUTCOMES IN SPONTANEOUS BACTERIAL PERITONITIS

[1]Jaclyn Yizhen Tan*, [1]Jade King, [1]Jennifer Ryan, [1]Marsha Y Morgan, [2,3]Emmanuel Q Wey, Rachel H Westbrook. *[1]UCL Institute of liver and digestive health, Division of Medicine, London, UK; [2]Division of Infection and Immunity, University College London, London, UK; [3]Department of Microbiology, Royal Free London, Centre for Clinical Microbiology, London, UK*

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Introduction In patients with Spontaneous Bacterial Peritonitis (SBP), acute kidney injury and high serum bilirubin are known predictors of in-hospital mortality. The effect of patient management on mortality is unknown. This study aims to identify predictors of in-hospital mortality, accounting for management of patients with SBP, according to EASL Clinical Practice Guidelines published in 2010.

Methods Clinico-demographic, biochemical and microbiological data from patients presenting between 2014 and 2019, with a first episode of SBP (ascitic fluid neutrophil count $\geq$ 250 cell/cm^3) were reviewed. The primary endpoint was in-hospital mortality. Logistic regression was used to identify predictors of outcome.

Results Overall, 130 patients (median [IQR] age 58 [51 - 66] yr; 65% male; aetiology: alcohol 36%; MELD score 18 [13 - 25]) were included. Infection was nosocomial in 49%; 35 had concomitant bacteraemia (n = 14), respiratory (n = 16) or urinary infections (n = 9). Pathogens were identified in 57 (44%) patients within 42 [36 – 50] hr post initial ascitic tap; antibiotic sensitivities were available by 53 [49 – 62] hr. Multidrug resistant pathogens (MDRP) were identified in 12 (21%) of the 57; 10 of the 12 showed < 25% reduction in ascitic neutrophil count at 48 hours.

There were 29 (22.3%) in-hospital deaths; the median time to death was 6 [1 – 8] days. A total of 31 (24%) patients were admitted to ITU and one-third (n = 13) of this cohort died. One patient underwent liver transplantation. On univariate analysis, admission MELD, peripheral white cell count, INR, serum creatinine, failure to culture a pathogen, failure to perform a 48-hour ascitic tap and development of acute kidney injury were predictors of in-hospital mortality. Age, nosocomial infection or the presence of a MDRP were not. Failure to perform a 48-hour ascitic tap (OR [95% CI] = 11.2 [2.9 – 43.7], p < 0.01), acute kidney injury (9.1 [2.0 – 41.5], p < 0.01) and MELD score (1.2 [1.1 – 1.3], p < 0.01) retained significance on multivariate analysis.

Conclusions In-hospital mortality associated with SPB is unacceptably high at 22%. Failure to repeat the ascitic tap at 48 hours, a recommendation based solely on expert opinion in the EASL guideline, was a highly significant prognostic factor allowing early identification of patients who fail to respond to empirical antibiotic therapy. This requirement should now become recommended practice.

P221 NON-CIRRHOTIC VS CIRRHOTIC HCC: COMPARISON BETWEEN PATIENT CHARACTERISTICS, AETIOLOGY AND OUTCOMES

[1]Jennifer Tham*, [1]Tee Lin Goh, [1]Stephen Barclay, [2]Matthew Priest, [1]Ewan Forrest, [2]Andrew Fraser, [1]Adrian Stanley. *[1]Glasgow Royal Infirmary, UK; [2]Queen Elizabeth University Hospital, Glasgow, UK*

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Introduction Hepatocellular carcinoma (HCC) causes more than 5,400 deaths per year in the UK and is rising in incidence. Previously in the UK, HCC in non-cirrhotic livers was felt to be uncommon. We sought to establish the proportion of HCC occurring in patients without cirrhosis in our region of the UK and compare characteristics of those with cirrhosis.

Methods Data was collected from our prospectively collected database on patient demographics, liver aetiology, stage at presentation and outcome for patients diagnosed with HCC at our regional MDT from 2009 to 2015.

Results A total of 638 patients with HCC were included. 140 (21.9%) had no underlying cirrhosis. Non-cirrhotic HCCs were older at diagnosis (72 years vs 68 years, p = 0.001), with a similar male to female ratio. Alcohol related liver disease (ArLD) was the most common underlying aetiology in patients with cirrhosis (59%; see table 1), and along with Viral hepatitis was significantly more common than patients without cirrhosis. In contrast, unknown aetiology represented the majority of diagnoses, and was significantly greater in the non-cirrhotic cohort. Patients with non-cirrhotic HCC had more advanced malignant disease at diagnosis compared to cirrhotic HCC using Barcelona Clinic Liver Cancer (BCLC) staging, p < 0.001 (table 1). Liver transplant was performed in 4.2% of patients with cirrhotic HCC compared to no patients with non-cirrhotic HCC. Liver resection was performed in 4% cirrhotic versus 9% non-cirrhotic. Radiofrequency ablation (RFA) was used in 7% and 1.4% of cirrhotic and non-cirrhotic HCC. Transarterial chemoembolization (TACE) was used in 25% cirrhotic and 24% non-cirrhotic HCC. Sorafenib was prescribed in 3% cirrhosis and 6.4% non-cirrhotic HCC, with Sorafenib plus TACE used in 1% cirrhotic and 1.4% non-cirrhotic HCC. 59% and 57% of patients with cirrhosis and non-cirrhotic HCC, respectively, were treated with supportive care only. Median survival was lower in patients with cirrhotic HCC, 19.6 months, compared to non-cirrhotic HCC, 24.5 months, p =0.05.