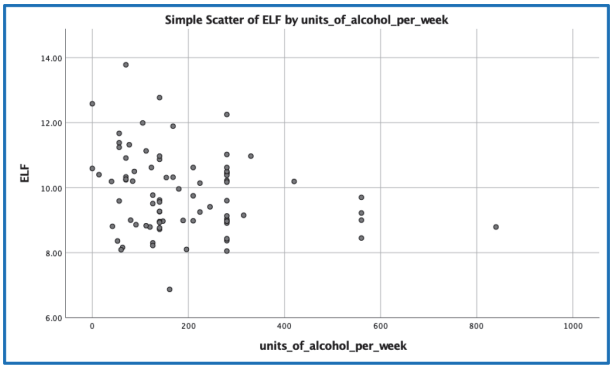

Abstract 210 Figure 1

associated with ELF score in multiple linear regression analysis, p = 0.168 (when adjusted for age, ALP, ALT, MCV, platelets and bilirubin) or when using binary ELF threshold of 10.5 (p = 0.366, OR 0.996, 95% CI 0.988–1.004). Neither BMI nor deprivation decile were associated with ELF score.

Conclusion In this cohort of patients with AUD, the amount of alcohol ingested was not associated with the ELF score suggesting that alcohol ingestion does not directly influence ELF results in AUD. ELF testing indicated that over a quarter of this cohort had advanced fibrosis, and 14% had cirrhosis (ELF≥ 10.5 and ≥11.3 respectively) in line with the literature. Further studies examining effects of alcohol unit thresholds on risk of liver fibrosis would be beneficial.

P211 ALCOHOL USE DISORDERS AND LIVER FIBROSIS – CASES ARE MISSED THROUGH FAILURE TO TEST

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Background and Aims Alcohol Use Disorders (AUD) account for 7.2% hospital admissions per year in the UK. While a proportion of these people are recognised to have liver disease and are managed by liver specialists, many are managed by a wide range of physicians and their liver disease may be missed even if their AUD is recognised. We aimed to use non-invasive tests for liver fibrosis to investigate the prevalence of occult liver disease in patients recognised to have AUD but not known to have liver disease.

Methods Prospective service evaluation of liver fibrosis in consecutive patients referred to the Alcohol Specialist Nurse (ASN) at the Royal Free Hospital from Nov' 2018-Dec' 2019. Patients were excluded if they were already known to have liver disease. Liver fibrosis was assessed using the Enhanced Liver Fibrosis (ELF) test performed on serum extracted from 5 ml of blood, analysed on an Advia Centuar. Patient demographic, blood test and imaging data were recorded along with alcohol histories. Patients with ELF scores ≥10.5 were invited for fibroscans and outpatient hepatology assessments.

Results We included 100 patients (69% male, mean age 53.15 ± 14.3). Median alcohol intake was 140 units/week (IQR 79.1–280), with duration of excess alcohol of 15 years (IQR 10–29). The commonest reason for presentation to hospital was symptomatic alcohol withdrawal (n=36/100). Other reasons included falls/trauma (13%), pancreatitis (9%), mental health (12%), GI bleed (5%) and 'other' (25%). None had a prior history of liver disease. Four patients had documented signs of CLD. Liver function tests, checked in 96/100 patients were abnormal in 64/96 (64%). ELF scores ranged from 6.87–13.78, median 9.66 (IQR 8.94–10.6). Of the total cohort, 29/100 (29%) had an ELF score ≥10.5. Of these, 29.6% had normal LFTs. 76% had previously attended A&E in the last 5 years, (median number of presentations = 4, IQR 2–9) without assessment or diagnosis of liver disease.

Conclusion Over a quarter of patients in this cohort with AUD had evidence of advanced liver fibrosis that had been undetected prior to 'opportunistic' ELF testing. The vast majority had had recent hospital attendances representing additional missed opportunities for investigating liver disease. LFTs cannot be relied upon to for detection of liver disease in AUD. We propose that clinicians consider using non-invasive tests to assess liver fibrosis in all patients admitted to hospital with AUD.

P212 EXPLORING BIOCHEMICAL AND IMMUNOLOGICAL PREDICTORS BETWEEN ACUTE AUTOIMMUNE HEPATITIS AND DRUG INDUCED LIVER INJURY

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Introduction Differentiating between acute autoimmune hepatitis (AIH) and acute drug induced liver injury (DILI) remains a major diagnostic challenge, as there are no definite pathognomonic biochemical, immunological or histological features for either condition. We aimed to explore markers that may help to ascertain the correct diagnosis and thereby prevent unnecessary long term use of immunosuppression in DILI.

Methods A retrospective case-note review of patients presenting with acute hepatitis at University Hospital Birmingham from 2010–2018. Data are reported with p-values from Fisher's exact tests or as a median with Mann-Whitney tests as applicable. Significance was set as p<0.05. Histological analysis is ongoing.

Results A total of 28 patients with acute presentation of AIH and 42 patients with DILI were identified. The age at presentation was similar in the two groups (median: 56 vs. 55 years), with a preponderance of females in the AIH group (79% vs. 48% of DILI, p = 0.013). AIH patients were significantly more likely to be ANA (82% vs. 17%, p < 0.001) or SMA (68% vs. 17%, p < 0.001) positive and to have significantly higher IgG (median 19 vs. 10 g/dl, p < 0.001).

At presentation, AIH and DILI patients had similar levels of AST, ALT and GGT. DILI patients had significantly higher ALP (median 258 vs. 126 U/L, p = 0.006), bilirubin (median 213 vs. 32 mg/dl, p < 0.001) and MELD scores (median 19 vs. 10, p = 0.001) but significantly lower ALT/ALP ratios (0.6 vs. 2.1, p = 0.048). Resolution of liver enzymes took significantly longer in the AIH group (median 54 vs. 13 weeks, p = 0.024). Liver histology is under review in both cohorts. All patients with acute AIH were treated with steroids, compared to 24% of those with DILI.