**Conclusion** This study shows operator feedback can dramatically increase LB adequacy. Single pass predicts sub-standard yield. In our study, switching from 18G to 16G calibre was not associated with significant increase in PT yield but did correlate with mild/moderate pain. CL ≥20 mm appears to be an accurate predictor of PT yield meeting the audit standard. Regular auditing and feedback can be an important tool to drive up the quality and yield of LB.

## REFERENCES

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## P380 INPATIENTS WITH ADVANCED ALCOHOL-RELATED LIVER DISEASE ARE NOT BEING CONSIDERED FOR TRANSPLANTATION: A REGIONAL AUDIT

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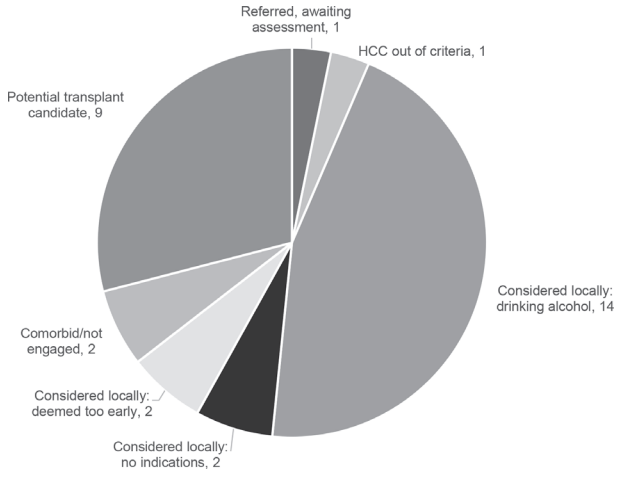
**Introduction** Alcohol-related liver disease (ArLD) remains a leading cause of premature mortality in the UK. In 2018/9 there were over 330,000 alcohol-specific hospital admissions and 5600 deaths. Although many of these patients have advanced disease and multiple admissions, there is a lack of data around access to liver transplantation.

**Method** A spot audit of all inpatients with ArLD was performed in 9 hospitals in the South West on a single day in February 2020. Anonymised data was collected using a standardised collection form on patient characteristics and documentation of consideration for transplantation.

**Result** 9 hospitals provided data: 1 tertiary, 2 large acute trusts and 6 district generals. 31 inpatients (20 [65%] male; median age 62 years [IQR 50–70]) were included. None were liver transplant recipients. 11 patients (35%) had alcoholic hepatitis. 90% had decompensation of ArLD: 84% had ascites (15% treated for SBP), 39% hepatic encephalopathy and 13% upper GI bleeding. Median UKELD was 58 (IQR 55–62) and MELD 21.5 (IQR 19–25). 56% had Child Pugh C and 39% Child Pugh B severity.

55% of patients were drinking alcohol at admission. 48% were known to alcohol services. Where data were available (14 cases) median intake of alcohol was 63 units/week (IQR 32–96). In the abstinent group, median duration of abstinence was 6 months (IQR 1.6–12).

Only 2 patients (6%) had documentation in the notes of being considered for transplantation (both deemed 'too early'). 1 patient had been referred for assessment at a transplant unit. There was no documentation in patient records in the remaining 28 patients (90%). In this group, eligibility for transplantation was considered. 19 patients were deemed illegible. Data were not available for 9 patients (figure 1).




**Abstract P380 Figure 1** Consideration for transplantation

**Conclusion** This regional spot audit demonstrates that inpatients with ArLD have advanced disease and suggests that this group is not routinely being considered for liver transplantation. We acknowledge that our data are limited by availability and accuracy of documentation in patient records. Although a small sample size, this represents inpatients in a variety of hospital settings across the whole of the South West. We aim to use this as a pilot for a national audit to evaluate access of ArLD patients to liver transplantation.

## P381 DEFINING HCV CIRRHOSIS BY FIBROSCAN SCORE HAS A SIGNIFICANT IMPACT ON HCC SURVEILLANCE BURDEN

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**Introduction** Patients with hepatitis C (HCV) related cirrhosis should undergo 6 monthly hepatocellular carcinoma (HCC) surveillance, as this has been shown to be effective in increasing longevity where the incidence of HCC is greater than 1.5% per year.[1] NHS England define HCV cirrhosis on Fibroscan®/transient elastography (TE) as a liver stiffness measure (LSM) >11.5 kPa[2] prior to commencing direct-acting antiviral (DAA) treatment. AASLD guidelines define HCV cirrhosis as a LSM score of >12.5 kPa, and >14 kPa has been used in other studies.[3] This lower score by NHS England may lead to a higher burden of HCC surveillance in HCV patients. This study aimed to assess the impact of HCC risk if higher LSM measurements are used to define cirrhosis, and to evaluate the impact on the subsequent ultrasound (US) surveillance burden.

**Methods** 100 patients with HCV with a LSM >11.5 kPa on TE using the local treatment database were identified, and from this 53 patients had a complete set of data at the time of the pre-DAA treatment Fibroscan® allowing a 3 year HCC percentage risk to be calculated using the validated HCC calculator.[4] The cirrhosis parameter within the risk score calculator was defined as a Fibroscan® score of either >11.5 kPa, >12.5 kPa, or >14 kPa, and comparisons were made of HCC risk between HCV cirrhosis and non-cirrhosis patients depending on LSM cut off for cirrhosis in each of these groups. Statistical significance between cirrhotic and non-cirrhotic HCC risk was performed using a Mann-Whitney test, and reduction in US surveillance burden was calculated as a percentage.

**Results** When HCV cirrhosis was defined as a LSM of >12.5 kPa, the 3 year risk of HCC was 2.91% compared to non-cirrhosis patients (LSM ≤12.5 kPa) who had a risk of 0.15% (p = <0.0001). HCV cirrhosis defined as a LSM score of >14

**Abstract P381 Table 1**

| Cut off for cirrhosis on TE (LSM in kPa) | Median 3 yr HCC risk (%) | |
|---|---|---|
| | HCV cirrhosis | HCV non-cirrhosis |
| >11.5 | 2.46 | - |
| >12.5 | 2.91 | 0.15 |
| >14 | 3.07 | 0.24 |

kPa conferred a 3 year HCC risk of 3.07% compared to non-cirrhosis (LSM ≤14 kPa) who had a risk of 0.24% (p = 0.0001). In both these groups where a higher LSM cut off for cirrhosis has been used, there was a significantly higher 3 year risk of HCC in the cirrhosis patients, and no patients within the non-cirrhosis groups had a 3 year HCC risk >1.5%.

Increasing the TE definition of cirrhosis from >11.5 kPa to >14 kPa in this cohort led to a 42.7% reduction in 6 monthly US surveillance in this cohort.

**Conclusions** Using the pre-DAA treatment HCV definition for cirrhosis (LSM >11.5 kPa) may be causing an unnecessary number of patients to undergo US surveillance, and changing the Fibroscan® definition of cirrhosis may have significant cost benefit. This needs to be assessed in a larger cohort.

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## P382 MULTIMODAL SAVINGS WITH THE INTRODUCTION OF A TELEPHONE CLINIC FOR STABLE PATIENTS WITH LIVER CIRRHOSIS

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**Introduction** Patients with stable cirrhosis require regular clinic review and surveillance for hepatocellular carcinoma with 6-monthly ultrasound and alpha-fetoprotein levels. We looked at the uptake and cost, environmental and clinical benefits of a new specialist nurse-led telephone clinic for patients with stable cirrhosis.

**Methods** Patients with both an established diagnosis of liver cirrhosis and stable disease (no ongoing insult to liver, no episodes of decompensation within preceding 12 months) were offered a nurse-led telephone appointment in place of a face-to-face clinic appointment. Those that accepted were contacted by the nurse at a designated time, with a proforma used to structure the consultation and to organise further investigations. If recent investigation results or the patient themselves raised concerns, a subsequent face-to-face appointment was organised with a consultant rather than continued review in the telephone clinic.

We measured service uptake and calculated and compared the costs of running a face-to-face clinic with that of a telephone clinic.

**Results** A total of 1,110 appointments were scheduled between November 2014 and February 2020, averaging 302 appointments per year. This equates to a capacity of around 20 consultant-led face-to-face clinics per year. We calculated the cost of running 20 such clinics (staffed by a consultant, clinic nurse and clinic clerk) as being £7,730. Conversely, the cost of running a nurse-led telephone clinic equates to roughly £1,300 per year, resulting in an annual saving to the trust of around £6,500 through this initiative.

Furthermore, a telephone clinic confers benefits to the patient as well. Per year, this clinic results in a saving of £10 on petrol and parking, around 5 hours of patient time and will reduce their carbon footprint by roughly 0.01 tonnes of carbon dioxide. Additionally, the use of a guidance-based proforma to structure the clinic should result in improved adherence to evidence-based guidelines.

Telephone clinics also reduce costs for the trust by freeing up staff and clinic rooms and by increasing clinic capacity for complex hepatology patients undergoing active treatment requiring face-to-face appointments. From the patient perspective, negating the need to physically visit the hospital in person obviates their need to take time off work and, certainly, feedback has been positive and there have been no complaints from users of this service.

**Conclusions** Our nurse-led telephone clinics have shown excellent uptake by patients, with no negative feedback received to date. These clinics provide a clinically sound, cost-effective method for following up stable patients with liver cirrhosis, with clear and multifaceted benefits for both the patient and the trust.

## P383 BIOLOGICS IN IBD: ARE WE ADHERING TO GUIDELINES?

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**Introduction** The use of biologics has revolutionised the management of inflammatory bowel disease (IBD). QEHB is a large tertiary referral IBD centre with over 600 patients on biologics.

However, biologics are expensive & have significant risks & side effects. Furthermore a majority of patients on biologics do not experience sustained long-term remission. Pre-treatment screening & comprehensive follow-up is key to ensuring appropriate use.

Our aim was to assess initiation of biologics & subsequent follow-up at QEHB against local guidelines based on NICE & ECCO guidelines.

**Methods** Retrospective data collection on 50 consecutive IBD patients starting on a new biologic between Oct 2017 &amp Jan 2018. We assessed adherence to our guidelines for pre-screening, MDT discussion, initial follow-up assessing response & 1 year follow-up.

**Results** **Gender**: 64% M; 36% F

**Disease**: 66% Crohn's; 34% UC

**Choice of biologic**: 42% adalimumab; 26% vedolizumab; 20% infliximab; 12% ustekinumab

Prior to starting biologics:

- 8% were not discussed at MDT (4% failed drug holiday, 2% transferred in on treatment)
- 10% had no baseline bloods within the last month
- 30% had no blood borne virus screen within 6 months
- 28% had no CXR prior to starting biologics