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

Abstract P383 Table 1

Guideline	Guideline followed (%)	Guideline not followed (%)
Discussed at MDT	92%	8%
Baseline bloods within 1 month of starting	90%	10%
Blood borne virus screen within 6 months of starting	70%	30%
CXR prior to starting	72%	28%
Quantiferon prior to starting	80%	20%
3 month clinic appointment on time	46%	54%
3 month consultant review	76%	24%
Clear decision made to stop or continue	76%	24%
Discussion about continuing biologic at 1 year?	64%	36%
Drug level check at 1 year	36%	64%

Following patients up:

- 54% did not have appropriate 1st follow-up appointment (32% early, 22% late)
- 24% had initial treatment response inadequately recorded
- 36% had annual inadequate recording at annual review of treatment response and plan to continue biologics
- 4% had their new biologic stopped at 1 year

Conclusions Results show that we are not following our local guidelines in a significant minority of cases. Some of this may be due to lack of recording or a consistent approach to assessments. Lack of outpatient resource prevents timely reassessment of patients and opportunities for dose titration or appropriate change of treatment are missed. The finding that 95% of patients were maintained on biologics after 12 month is at odds with published response rates & it is possible that patients are continuing treatment which is not effective.

To address the failures shown by this audit we propose alternative models including virtual review. Annual review will consist of a consultant led remote review of response to biologic & a decision on ongoing treatment. A proposed IBD pharmacist will aid with optimal dosing and adherence to protocol.

P384 DOES BLOOD DONATION IN GENETIC HAEMOCHROMATOSIS MATCH THE DEMANDS OF THE UK BLOOD TRANSFUSION SERVICES?

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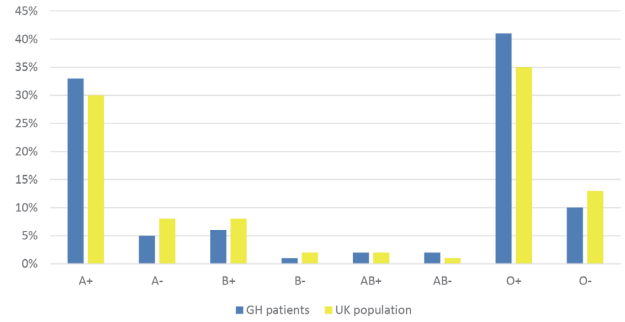
Introduction In patients with Genetic Haemochromatosis (GH) and iron overload, the mainstay of treatment is venesection. Current UK[3] and European[4] guidelines recommend that, in uncomplicated haemochromatosis, therapeutic venesection should be undertaken at a blood donor centre in order that blood can be utilised by transfusion service. However, given that GH occurs almost exclusively amongst North European Caucasians, we aimed to determine whether the blood donated from our GH cohort matched the needs of the blood donation service.

Methods A specialist haemochromatosis clinic was established in a tertiary liver centre to standardise care and facilitate blood donation amongst this cohort. Data on all those attending was collected along with blood type, where available. Data was collected on new referrals to the local blood donor service along with blood type of those donating. Population blood type data was sourced from NHS Blood and Transplant.[3]



Abstract P384 Figure 1 Blood type comparison – our GH cohort with UK population

Results Since implementation, 187 patients have been seen in the specialist clinic (117 male; median age 59). Of these, 50 are now blood donors. Overall, blood type was available in 114. Distribution of blood types amongst our GH cohort was very similar to the UK donor population (figure 1). The commonest type in both was O+ (41% GH; 35% UK) followed by A+ (33% GH; 30%) then O- ['universal donors'] (10% GH; 13% UK). Rh genotyping had been done on some donors to enable better matching of blood products to patients. The Ro subtype of RhD+ was identified in 1 patient.

Conclusion The blood types of our North-East GH cohort were almost identical to that of the UK donor population which is less ethnically diverse than the general UK population. Whilst each donation is beneficial, there are higher demands for certain blood types. Priority blood groups are O-, the 'universal donor', and the Ro subtype of RhD+; the latter needed for increased demand patients with sickle cell disease. These blood types constituted only a small number of our cohort. However, there is a willingness to donate amongst GH patients. Implementing a service to facilitate blood donation for GH patients more widely would proportionally increase the availability of all blood types whilst also affording the opportunity to maximise communication with and recruitment of 'Priority Blood Group' donors.

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P385 NATIONAL SURVEY EVALUATING THE PROVISION OF GASTROENTEROLOGY DIETETIC SERVICES IN ENGLAND

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