**Abstract P221 Table 1** Comparison of Aetiology and BCLC staging classification in patients with cirrhosis and non-cirrhosis HCC

| | Cirrhotic (N=497) | Non-cirrhotic (N=140) | P-value |
|---|---|---|---|
| **Aetiology** | | | |
| ArLD | 293 (59.0) | 45 (32.1) | <0.00001 |
| Viral | 104 (20.9) | 15 (10.7) | 0.006 |
| NAFLD | 89 (17.9) | 19 (13.5) | 0.227 |
| Other | 59 (11.9) | 14 (10.0) | 0.539 |
| Unknown | 80 (16.1) | 76 (54.2) | <0.00001 |
| **BCLC** | | | |
| Stage 0/A | 97 (19.5) | 12 (8.6) | |
| Stage B | 103 (20.7) | 41 (29.3) | |
| Stage C | 171 (34.4) | 64 (45.7) | |
| Stage D | 126 (25.3) | 23 (16.4) | |

**Conclusion** In our study nearly 22% of HCCs occurred in patients without underlying cirrhosis. A high proportion of non-cirrhotic HCC patients had unknown aetiology of liver disease. Patients with non-cirrhotic HCC were diagnosed at an older age with more advanced disease but lower mortality compared to patients with cirrhotic HCC.

## P222 DOES RIFAXIMIN AFFECT HOSPITAL ADMISSIONS AND MORTALITY?

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**Introduction** Hepatic encephalopathy (HE) is a common complication of liver cirrhosis. HE often results in frequent and longer hospital admissions and increased mortality. Rifaximin is recommended by NICE to reduce the rate of HE in adults with overt encephalopathy.[1] We examined the efficacy of rifaximin in preventing hospital admissions or disease progression.

**Method** All patients who were prescribed rifaximin from the hospital pharmacy between June 2016 and 2017 were collated. These patients' details were investigated using clinical databases including JACS, Medisec, ICE and clinical notes.

**Results** 75 patients were prescribed rifaximin for HE. 61 (78%) of the patients prescribed rifaximin for HE continued rifaximin indefinitely or until their death. The mean course length was 314 days (3sd). 41% of the patients started on rifaximin for HE died, the average time between starting rifaximin and death was 265 days (3sd). The one-year mortality rate of those on rifaximin for HE was 24%; compared to the one-year average mortality rate of HE of 42%, suggesting that rifaximin may associate with an improvement in mortality.[2] The readmission rate of the remaining patients (those who did not die) was 81%; reflecting high readmission rates associated with HE. From hospital discharge letters the reason for the patients' readmissions was identified. 70% of the patients did not have a HE-related admission once they started rifaximin.

43 patients (57%) on rifaximin spent less than a fortnight in hospital in the year following the start of treatment. For every patient's first to third readmission after starting rifaximin a MELD score was calculated. For these readmissions the average MELD score remained 15–16 (2 sd). This suggests that with rifaximin patient's severity of liver disease and life expectancy remains stable over the time investigated.

**Abstract P222 Table 1**

| | Still on rifaximin | Stopped Rifaximin |
|---|---|---|
| Readmission with HE in 1st year of treatment | 30 | 1 |
| Readmission with confusion but no documented HE in 1st year of treatment | 7 | 0 |
| Readmission with no HE in 1st year of treatment | 105 | 19 |
| Readmission of unknown cause in 1st year of treatment | 10 | 0 |

**Conclusion** Rifaximin use associates with a reduction in recurrence of HE, hospital readmission and mortality. These findings need replicating in multicentre studies

### REFERENCES

1. Rifaximin for preventing episodes of overt hepatic encephalopathy [Internet]. NICE. 2015 [cited 2019 Oct 24]. Available from: https://www.nice.org.uk/guidance/ta337/chapter/1-Guidance
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## P223 DYING FROM LIVER CIRRHOSIS. ARE WE COMMUNICATING WITH PATIENTS AND THEIR RELATIVES?

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**Introduction** The prospect of dying is often a difficult subject to broach with patients and their relatives.[1] This is especially difficult in patients with advanced liver disease due to the unpredictable trajectory of the disease. We therefore aimed to investigate whether we were communicating this with patients and their next of kin (NOK).

**Methods** We assessed the notes of patients who had 'cirrhosis' or 'liver disease' documented on their death certificates during April- September 2019. This included reviewing all documentation during admissions and clinic attendances focusing on whether prognosis or the risks of dying were discussed. We analysed prognostic indicators including Child Pugh, number of admissions in the last six months, WHO performance status, refractory ascites, alcohol intake, hepatic encephalopathy (HE) and whether they had been assessed for liver transplant.

**Results** We reviewed the notes of 19 patients (8 male,11 female). The mean age of death was 60 years, the median 58 years. 84% of patients died in hospital with a median length of stay of 8.5 days. Going through the case records 69% of patients had no discussion about cirrhosis and its life limiting implications leading up to the last hospital admission (2 previously not seen,1 declined discussion). 1 patient had a discussion about palliative care options before their last admission. 43% of NOK had a discussion documented before the last admission (2 excluded as first presentations, 1 excluded as no NOK).