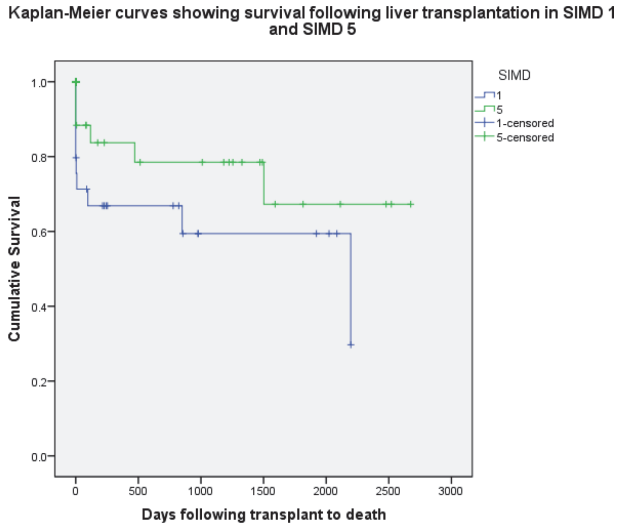

Abstract P198 Figure 1 Kaplan-Meier curves showing survival following liver transplantation in SIMD 1 and SIMD 5

the effect of socio-economic deprivation by comparing survival in the most and least deprived groups in the transplanted and not listed groups. A significance level of $p<0.05$ was used with the Log rank test.

Deprivation was assessed using the Scottish Index of Multiple Deprivation (SIMD) and groups were paired for analysis (group 1 most deprived; group 5 least deprived)

Results When including all patients those transplanted (n=562; 103 deaths) had a significantly better survival than those not listed (n=230; 139 deaths) (Mean survival 2219 days (95% CI 1912–2526) vs. mean survival 645 days (95% CI 563–726). (Log rank $p<0.001$).

There was no difference in survival when comparing the most deprived to the least deprived (SIMD 1 (n=84; 56 deaths) vs. SIMD 5 (n=32; 16 deaths)) in those patients not listed for transplant. (Mean survival 658 days (95% CI 474–842) vs. mean survival 680 days (95% CI 367–994). (Log rank $p=0.969$).

When comparing survival in the most deprived (n=133; 32 deaths) to the least deprived (n=86; 13 deaths) in those patients that were transplanted, patients from the more deprived areas had a poorer survival. (Mean survival 1373 days (95% CI 1027–1719) vs. mean survival 1998 days (95% CI 1596–2400) (Log rank $p=0.046$).(Figure 1).

Conclusions Overall liver transplantation gives a significant survival advantage compared to those not listed. Patients from more affluent areas of Scotland have improved survival to those from less affluent areas when transplanted. No difference is seen in those patients not transplanted.

P199 IMPACT OF A DISCHARGE PROFORMA ON THE MANAGEMENT OF PATIENTS WITH DECOMPENSATED LIVER DISEASE

[1]Holly Fraser, [2]Stuart McPherson, [1]Dina Mansour*. [1]*Queen Elizabeth Hospital, Gateshead, Newcastle Upon Tyne, UK*; [2]*Royal Victoria Infirmary, Newcastle upon Tyne, UK*

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Objectives To produce and implement a discharge proforma, with the aim of improving record keeping and management of patients with decompensated cirrhosis. Decompensated liver disease is associated with a high mortality and can manifest in a variety of manners; thus it is important that certain aspects of these patients' admissions are clearly documented and easily accessible.

Design Discharge letters of 61 patients with decompensated liver disease who had been admitted to QEH between 2017 and 2018 were reviewed and compared to a proforma developed by the gastroenterology team at the RVI (with permission). A similar discharge proforma was developed and integrated for use on the gastroenterology ward at the Queen Elizabeth Hospital, and subsequent discharge letters in 2019 were audited (further 27 letters).

Results The implementation of a discharge proforma enhanced documentation of key features of patient admissions for decompensated cirrhosis. In the 2017–2018 letters 45.0% of key features were documented; this rose to 67.0% in the 2019 letters following implementation of the proforma. In addition, there was a 44% reduction in the number of inpatient deaths and 55% and 64% reduction in readmissions (within 30 and 90 days, respectively), following the introduction of the discharge proforma.

Areas which remain poorly documented despite the proforma include renal function, Child Pugh score/prognosis and variceal grading.

Renal function documentation improved marginally with 9 of the 2019 patient letters containing documentation of renal function, as opposed to the 0 letters across 2017 and 2018; however this still only equates to 33.3% of the discharge proformas containing information about patients' renal function. Child Pugh score was not documented for any of the 2019 cohort and the grade of varices was documented in just one of the discharge proformas (16.7% of 2019 cohort), which is a 20.8% and 10.6% reduction compared to the 2017 and 2018 discharge letters.

Conclusions Implementation of a discharge proforma for decompensated liver disease patients is associated with fewer inpatient deaths, a reduction in readmissions and improved documentation in their discharge letters. Further work is required with the implementation of the proforma, particularly around education regarding its use, to ensure it is utilised appropriately. A similar project is being undertaken at the RVI, with the aim of producing a proforma for the British Society of Gastroenterologists.

P200 REAL-LIFE COMPARISON OF TRANSIENT ELASTOGRAPHY (FIBROSCAN®) TO LIVER BIOPSIES: A UK DISTRICT GENERAL HOSPITAL EXPERIENCE

[1]Georgios Marinopoulos*, [1]Maja Kopczynska, [1]Bethany Miller, [2]Mahesh Bhalme. [1]*Salford Royal NHS Foundation Trust, Manchester, UK*; [2]*Bolton NHS Foundation Trust, Bolton, UK*

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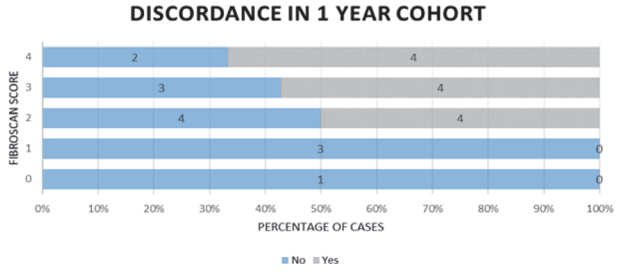
Background and Aim Over the last decade, the development of liver stiffness measurement using transient elastography (FibroScan®) and its widespread use has become the standard for non-invasive staging of liver fibrosis. Our study explores a real-life experience on concordance of fibrosis staging between the fibroscan and the liver biopsies aiming to assess its reliability.

Method We conducted a retrospective study between September 2014 and May 2019 comparing fibroscan and liver biopsy findings. The FibroScan 502 Touch results were interpreted to

give the Metavir fibrosis score. Where necessary, the Ishak score of the histology samples was converted to a Metavir equivalent. Discordance was defined as a difference of ≥ 2 stages between the two modalities of staging fibrosis and was analysed using the Chi square test. We analysed the data within a one year duration between the fibroscan and liver biopsy.

Results During the study period, an overall total of 199 liver biopsies and 1218 fibroscans were undertaken. Twenty-five patients had both a fibroscan and a liver biopsy performed within a one year interval. The mean and median interval between fibroscan and biopsy was 42 and 28 days respectively. The median fibroscan stage was F3 (range 0–4) and the median liver biopsy stage was F1 (range 0–4). When compared to the liver biopsy, an identical fibroscan based fibrosis score was obtained in 4 (16%) cases. Fibroscan had understaged 2 (8%) and over staged 19 (76%) cases while discordance was noted in 12 (48%) cases (figure 1). Discordance was not statistically different for F0-1 in comparison to F2-4 scores (p=0.311), however, fibroscan score of F0-1 was significantly more likely to have identical value of Metavir score for both fibroscan and liver biopsy (p=0.009) (figure 1).



Abstract P200 Figure 1

Conclusion Fibroscan with lower fibrosis scores (F0-1) had higher concordance to the liver biopsy based histological staging and therefore can be used safely to exclude significant fibrosis. Moderate to severe fibrosis staging (F2-4) showed increased disparity between the biopsies and the fibroscan scores, with the latter usually over-staging the level of fibrosis. We therefore feel fibroscan in isolation may not be suitable to diagnose advanced liver fibrosis.

P201 BEZAFIBRATE AS SECOND LINE TREATMENT IN PATIENTS WITH PRIMARY BILIARY CHOLANGITIS: A REAL WORLD EXPERIENCE

Rebecca McCabe*, Martin Prince, Shaun Greer, Harpreet Dhaliwal. *Manchester Foundation Trust, Manchester, UK*

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Introduction Failure to improve alkaline phosphatase (ALP) with treatment with Ursodeoxycholic acid (UDCA) is associated with reduced transplant-free survival in primary biliary cholangitis (PBC). Bezafibrate (BZ), as second line treatment, has been shown to be effective in improving ALP in patients with PBC in a recent randomised controlled trial[1] but 'real world' data is limited.

Aim and Method The aim of this study was to retrospectively assess the effectiveness of BZ as second line treatment in patients intolerant of, or non-responsive to UDCA in a single tertiary referral centre.

ALP was recorded at six and twelve months of treatment and compared to baseline. Biochemical response was defined by the Toronto criteria of ALP less than 1.67 times the upper limit of normal. Results are expressed as median (range).

Results 36 patients were identified as treated with BZ. Eight have been excluded as lost to follow-up (n=1) or had been taking BZ less than six months (n=7).

Of the remaining 28 (5 UDCA intolerant, 23 UCDA incomplete response), 23 were female, median age was 54 (32–85) at the start of treatment and 11 patients (40%) had cirrhosis.

Three (10.7%) patients stopped treatment due to intolerance (deteriorating renal function n=1; cramps n=1 and gastrointestinal symptoms n=1). The latter were both also intolerant to UDCA.

In the remaining 25, ALP fell from 279 (125–782) to 154 (74 – 415) at six months, with 76% achieving biochemical response by Toronto criteria.

16 patients have completed 12 months of treatment, with 12 patients (75%) achieving biochemical response. ALP fell from 281 (125 – 720) to 138.5 (90–326) at 12 months. 7 (44%) patients normalised ALP.

20 patients were asked about pruritis before and after treatment. 6 patients (30%) reported no itch either before or after treatment, 2 (10%) reported no change in severity and 12 patients (60%) reported improvement in pruritis.

Conclusion We have found that BZ is an effective second-line treatment, with 75% of those who tolerated it achieving biochemical response at 12 months. It was well tolerated and was also associated with improvement in pruritus in the majority of patients. Further research is required to assess the long-term outcome in these patients.

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P202 CHECKPOINT INHIBITOR IMMUNOTHERAPY INDUCED HEPATOTOXICITY IN PATIENTS WITH METASTATIC MELANOMA: THE NORTHERN IRELAND EXPERIENCE

Stuart McIlwaine*, Rebecca Gregory, Therese McCartney, Caroline Forde, Conor O'Neill, Conor Braniff, Johnny Cash, Bode Oladipo. *Belfast Health and Social Care Trust, Belfast, UK*

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Introduction The emergence of checkpoint inhibitor immunotherapy (IO) has revolutionised outcomes for patients with metastatic melanoma, with significantly improved response rates and survival shown in clinical trials. This treatment modality is however associated with unique toxicities including hepatotoxicity.

We aimed to determine if the clinical outcomes and hepatotoxicity rates in our routine clinical practice were comparable to those in existing literature.

Methods Patients receiving combination IO (Ipilimumab and Nivolumab) at the Northern Ireland Cancer Centre for metastatic melanoma between 1st September 2016 and 1st January 2020 were identified from an electronic database. Clinical characteristics of the disease, type and grade of hepatotoxicity (maximal rise of ALT or AST), treatment required and time to