Preliminary results from the BASL/BSG audit of PBC

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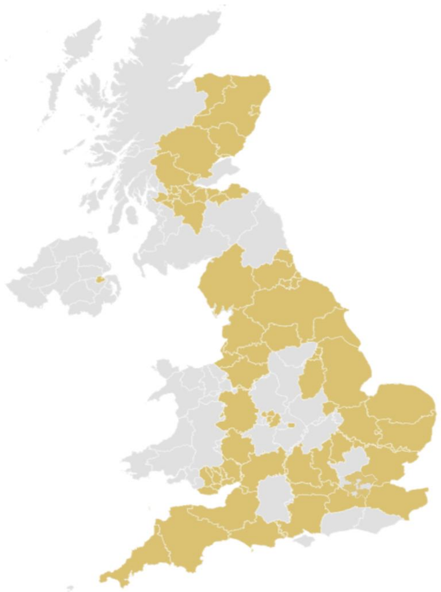
Introduction

- The BASL/BSG PBC audit is a collaborative project between BASL, BSG, UK-PBC and the PBC Foundation.
- It is the first national audit to benchmark the current management of PBC against the BSG audit standards devised in 2018.
- This audit will help trusts identify key areas for improvement, and critically, identify patients still in need of second-line treatment.
- 130 trusts are involved in the audit to date, with data uploaded for over 5,300 patients.
- Here we present the preliminary audit results from the completed East of England dataset.

East Midlands **68**
East of England **774**
Kent, Surrey, Sussex **267**
Mersey **265**
North Central London **167**
North East London **72**
North West London **112**
North Western **192**
Northern **484**
Northern Ireland **15**
Oxford **267**
Scotland **461**
Severn **195**
South London **331**
South West Peninsula **363**
Wales **94**
Wessex **205**
West Midlands **383**
Yorkshire & the Humber **589**



Methods

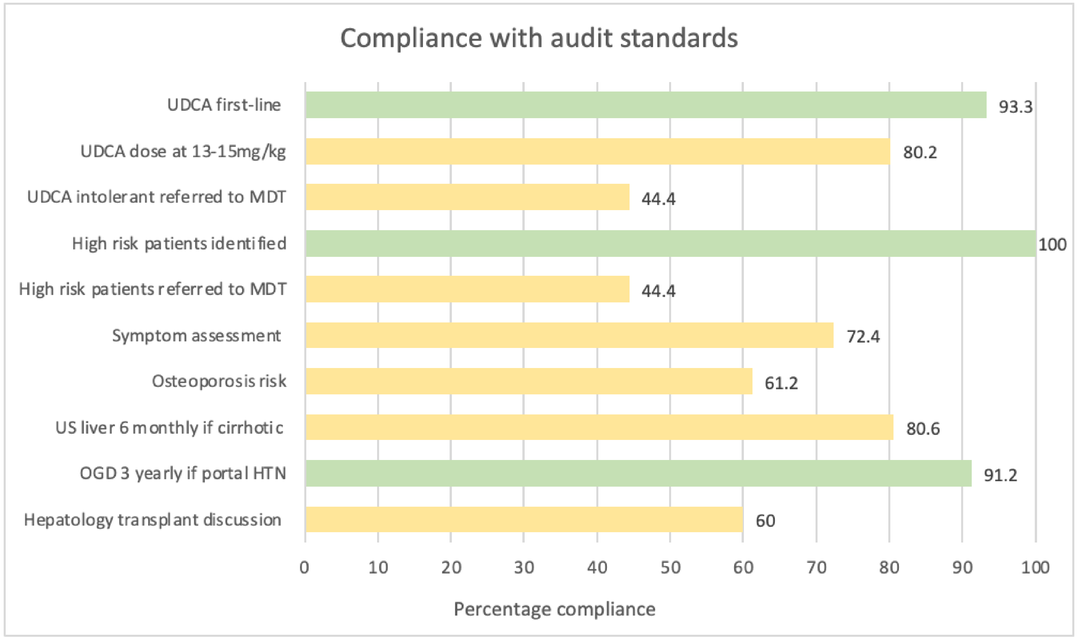
- We analysed audit data for 799 patients with PBC across 12 NHS hospitals in the East of England.

Hospital	Participants	Hospital	Participants
Addenbrooke's Hospital	243	Luton & Dunstable	121
Basildon Hospital	25	Norfolk & Norwich	94
Bedford Hospital	41	Peterborough City Hospital	40
Broomfield Hospital	56	Princess Alexandra Hospital	22
Ipswich Hospital	18	Southend Hospital	81
James Paget Hospital	24	West Suffolk Hospital	34

- The audit data was compared to the following key audit standards derived from the BSG PBC treatment and management guidelines:

1. All patients should be offered first-line therapy with UDCA. **(standard 90%)**
2. All patients on UDCA therapy should be on an adequate dose of 13–15mg/kg/day. **(standard 90%)**
3. All patients intolerant of UDCA should be referred to the MDT for second-line treatment. **(standard 90%)**
4. All high-risk patients should be identified using biochemical response indices following 1 year of UDCA therapy. **(standard 90%)**
5. All patients identified as high-risk for disease progression should be referred to the MDT for second-line treatment. **(standard 90%)**
6. All patients should be evaluated for the presence of symptoms, particularly fatigue and itch, within the last year. **(standard 90%)**
7. All patients should have a risk assessment for osteoporosis within the last 5 years**. (standard 80%)**
8. All patients with cirrhosis should have an US liver on a 6-monthly basis. **(standard 90%)**
9. All patients with portal hypertension should have had a gastroscopy within the last 3 years. **(standard 90%)**
10. All patients with a bilirubin >50 µmol/L or evidence of decompensated liver disease should be discussed with a hepatologist linked to a transplant programme (within 3 months). **(standard 90 %)**

Results



Cohort: 799 patients, 86.4% female, modal age range 70-79

Conclusions

- As a region we are performing well in some important areas, such as ensuring patients are on UDCA as first-line therapy and identifying patients at high-risk of disease progression.
- There are several areas where we could do better, in particular referring UDCA-intolerant or high-risk patients to the MDT for second line therapy. Improving understanding of referral criteria and pathways should hopefully enhance our performance in these areas.
- The proportion of patients on an adequate UDCA dose could be improved, and acts as an important reminder to review patient weight regularly, to ensure optimal dosing. Where UDCA is used intentionally at a sub-optimal dose, this should be clearly documented in the notes.
- Whilst we are meeting targets for variceal screening, we are slightly below target for HCC surveillance in cirrhotic patients, although this may reflect the radiology backlog most hospitals are facing following the pandemic.
- Discussion with transplant hepatologists is a key area for improvement, and we should be aiming for all eligible patients with prolonged jaundice or evidence of decompensation to be discussed for consideration of transplant assessment. Where discussion has taken place, this should also be clearly documented in the notes.