BEST

Barnsley Education Support and Training

Wednesday 17th January 2024

NHS
Barnsley Hospital
NHS Foundation Trust

Abnormal LFTs pathway

Dr Vinay Sathyanarayana

17th Jan 2024

PROUD to care

Liver disease

- Deaths due to liver disease increasing exponentially (~400% between 1970-2010
- SMR for <65 year olds >500%; 64,000 years of working life lost every year
- ~6,000 liver cancers/year
- ~ 50% increase over last decade
- Around 1/3 diagnosed at early stage

Contd

- Liver cancer survival:
  - Stage 1- Five year survival 50-70%
  - Stage 4- Average survival 4 months
- Primary risk factors
  - Alcohol
  - Metabolic dysfunction associated steatotic liver disease-MASLD
  - Others include viral hepatitis, haemochromatosis, autoimmune hepatitis

Early detection = better survival

Early Diagnosis of Liver Cancer Priorities 23/24

1. Delivery of 30,000 fibroscans of high-risk populations via the Community Liver Health Checks (CLHC) pilot by end of 2023/24

2. National Programme team to support Cancer Alliance to support Liver Services to invite >80% of patients at high risk of advanced fibrosis OR cirrhosis to 6-monthly ultrasound surveillance, with an aim of >60% of those invited to attend by 2024/25

3. Launch a primary care case finding SEARCH tool to be piloted in 2023/24 prior to national rollout in 2024/25

Delivery of Case Finding

This patient list is broken down into three priority groups:

- Group 1:
  - known alcoholic related liver disease
  - diabetes
  - hepatitis C
  - hepatitis B
  - known NASH
- Group 2:
  - known high intake of alcohol
  - NAFLD *with high risk of fibrosis*
- Group 3:
  - high risk of undiagnosed viral hepatitis (IVDU)
  - known NAFLD and low risk of NASH
  - high risk of NAFLD

Abnormal Liver Function Tests LFT

Bili, ALT, AST, ALP, GGT

Compare with previous results to assess trend. Any persistent abnormality needs further assessment.

Abnormal LFT's are a common reason for referral into secondary care.
There is a growing burden of NALFD being referred to secondary care.
A significant proportion of these patients can be safely managed in primary care.

History

Alcohol history* /Metabolic Syndrome & BMI Drug history** risk factors for viral hepatitis/ family history

Hepatic Synthetic failure
↑Bilirubin↓ Albumin ↑INR ↑PT
OR
suspected malignancy
Weight loss
Marked Cholestasis

Urgent Referral
Urgent ultrasound and/or urgent referral to secondary care

Urgent Referral: ALT> 1000
Viral hepatitis
Ischaemic hepatitis
Drug-induced liver injury (paracetamol)
(Autoimmune hepatitis)

sound scan

NILS Blood Tests
(On ICE look for the Abnormal LFTs panel)
LFTs, U&Es, Clotting profile, CRP
Iron profile
Immunoglobulins
Auto-antibody profile (ANA, ASM, AMA, ALKM)
Hepatitis B & C
Hepatitis A and E if ALT > 1000
tTg (Coeliac screen)
Alpha-1-Antitrypsin (A1AT)
Caeruloplasmin (if < 40 years of age)
Alpha fetoprotein
Fasting lipid profile

Hepatic liver enzymes
↑ALT or ↑AST

Normal USS and negative NILS

ALP & AST remain abnormal

NAFLD RISK FACTORS
T2DM
BMI.25
Dyslipidaemia
Hypertension

Yes

There is a growing burden of NALFD being referred to secondary care.
A significant proportion of these patients can be safely managed in primary care.

Likely NAFLD ***
(Non-Alcoholic Fatty Liver Disease)
+/- Metabolic Syndrome
SEE BELOW

Case 1

- 85 year old female; diabetes, hypertension
- Vague abdominal discomfort, yellow, weight loss, loss of appetite
- Bloods: Bili 100, ALT 130, AST 140, ALP 450

Hepatic Synthetic failure
↑Bilirubin↓ Albumin ↑INR ↑PT
OR
suspected malignancy
Weight loss
Marked Cholestasis

Urgent Referral
Urgent ultrasound
and/or
urgent referral to
secondary care

Urgent Referral: ALT> 1000
Viral hepatitis
Ischaemic hepatitis
Drug-induced liver injury
(paracetamol)
(Autoimmune hepatitis)

Case 2

- 45 year old male; fit+well
- Jaundice, lethargy, malaise
- Bloods: Bili 100, ALT 2500, AST 2900, ALP 180
- USS/MRCP- NAD

Hepatic Synthetic failure
↑Bilirubin↓ Albumin ↑INR ↑PT
OR
suspected malignancy
Weight loss
Marked Cholestasis

Urgent Referral
Urgent ultrasound
and/or
urgent referral to
secondary care

Urgent Referral: ALT> 1000
Viral hepatitis
Ischaemic hepatitis
Drug-induced liver injury
(paracetamol)
(Autoimmune hepatitis)

Case 3

- 33 year old male
- Vague abdominal symptoms
- Bloods: Bili 35, rest of LFTs normal; FBC normal

Isolated raised Bilirubin
with otherwise normal liver blood tests

Most commonly due to Gilbert's syndrome

Less commonly due to haemolysis
(consider reticulocyte count, LDH haptoglobin)

Bili <65
Patient well:
check FBC & blood film to exclude haemolysis
if normal :possible Gilberts
(repeat bil 1-3 months)

Gilberts Syndrome
Confirmed tell patient

Bili >65
Advice and guidance gastroenterologist

Case 4

- 76 year old male
- Background of CA prostate-treated with prostatectomy 6 years ago
- Routine bloods: ALP 1300, GGT 60

Case 5

- 65 year old female
- Family h/o autoimmune thyroid disease
- Routine bloods: Bili18, ALT 90, AST 60, ALP 110

- USS-NAD
- ANA ++; ASMA ++; IgG 22

Case 6

- 55 year old male; diabetes, alcohol >50 units/wk, obese, hypertension, dyslipidemia
- BMI 33
- Diabetes follow up bloods: Bil 11, ALT110, AST 80, ALP 160

PROUD to care

NHS Barnsley Hospital NHS Foundation Trust

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History
Alcohol history* /Metabolic Syndrome & BMI Drug history**/ risk factors for viral hepatitis/ family history

NILS (Non-Invasive Liver Screen) including Abdominal Ultrasound scan

Clinical Pattern Recognition
↑ AST/ALT = hepatocellular damage
↑ GGT/ALP = cholestasis
AST >> ALT = alcohol
ALP >> GGT = bone disease, pregnancy
GGT >> ALP = alcohol, medications**

NILS Blood Tests
(On ICE look for the Abnormal LFTs panel)
- LFTs, U&Es, Clotting profile, CRP
- Iron profile
- Immunoglobulins
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Gilberts Syndrome
Confirmed tell patient

Bili >65
Advice and guidance gastroenterologist

Isolated ↑ ALP only
Check vit D levels

If Vit D low
Tx as per Barnsley Guidelines

If Vit D levels normal
advice and guidance gastroenterologist

Isolated Cholestatic liver enzymes
↑ALP & ↑GGT

Hepatic liver enzymes
↑ALT or ↑AST

Abnormal USS and/or positive NILS

Normal USS and negative NILS

ALP & GGT remain abnormal.

ALP & AST remain abnormal

Refer to secondary care Hepatology Clinic

NAFLD RISK FACTORS
T2DM
BMI.25
Dyslipidaemia
Hypertension

No

Yes

There is a growing burden of NALFD being referred to secondary care.
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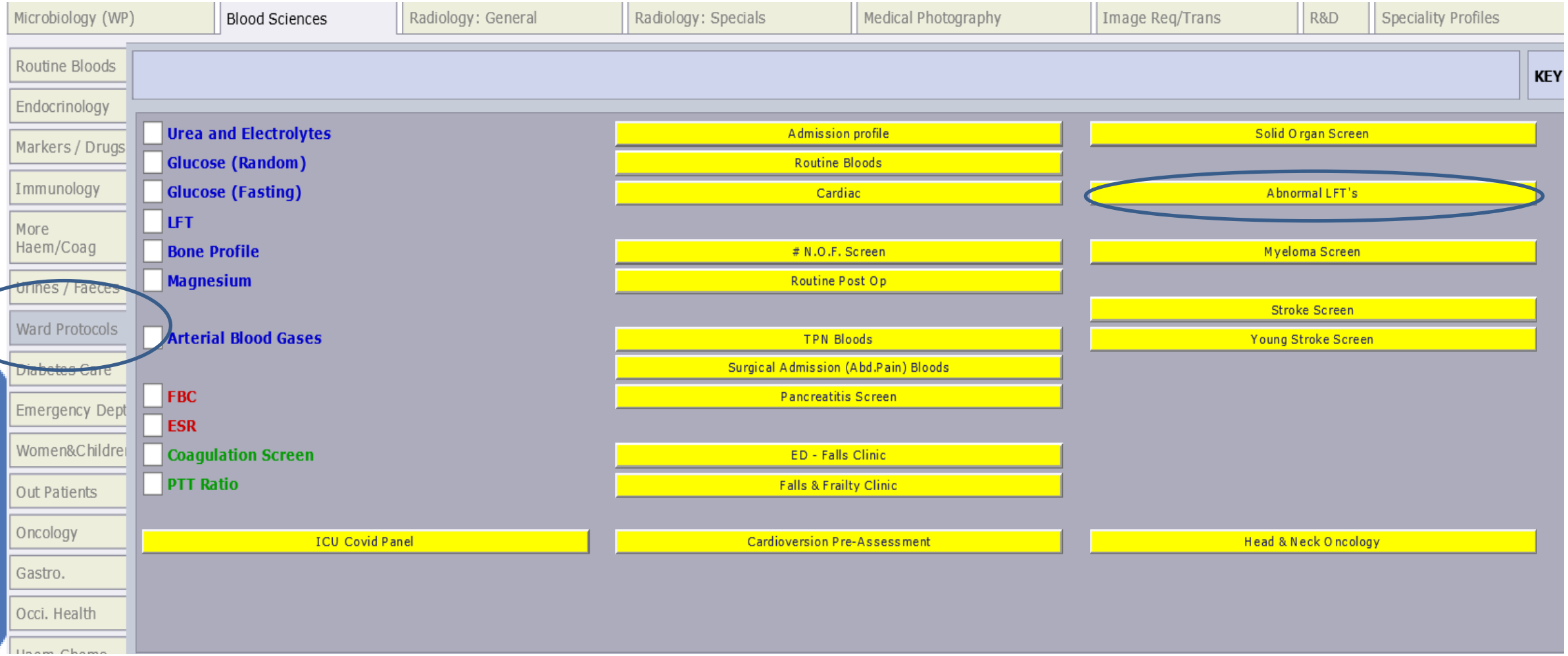

Microbiology (WP)
Blood Sciences
Radiology: General
Radiology: Specials
Medical Photography
Image Req/Trans
R&D
Speciality Profiles
Routine Bloods
Endocrinology
Markers / Drugs
Immunology
More Haem/Coag
Urines / Faeces
Ward Protocols
Diabetes Care
Emergency Dept
Women&Childre
Out Patients
Oncology
Gastro.
Occi. Health
KEY
Urea and Electrolytes
Glucose (Random)
Glucose (Fasting)
LFT
Bone Profile
Magnesium
Arterial Blood Gases
FBC
ESR
Coagulation Screen
PTT Ratio
Admission profile
Routine Bloods
Cardiac
N.O.F. Screen
Routine Post Op
TPN Bloods
Surgical Admission (Abd.Pain) Bloods
Pancreatitis Screen
ED - Falls Clinic
Falls & Frailty Clinic
Solid Organ Screen
Abnormal LFT's
Myeloma Screen
Stroke Screen
Young Stroke Screen
ICU Covid Panel
Cardioversion Pre-Assessment
Head & Neck Oncology

Abnormal LFT's

- [ ] ESR
- [ ] Ferritin
- [ ] Immunoglobulins
- [ ] Liver/Kidney/ Stomach Antibodies (LKS)
- [ ] A1AT & Caeruloplasmin
- [ ] Alpha Feto Protein
- [ ] Hepatitis B surface Antigen
- [ ] Hepatitis C Antibodies
- [ ] Coagulation Screen
- [ ] Iron Profile
- [ ] FBC
- [ ] Urea and Electrolytes
- [ ] LFT
- [ ] C Reactive Protein (CRP)

Methods of assessing liver fibrosis

- Gold standard- liver biopsy
- Proprietary blood tests: ELF (Enhanced Liver Fibrosis)
- Transient elastography (Fibroscan^{R,} ARFI)
- Composite markers on routinely available bloods:
  - FIB4 (Age, ALT, AST and Platelets)
  - APRI (AST to Platelet ratio)
  - NAFLD Fibrosis Score (Age, BMI, presence of diabetes, AST, ALT, Platelet)

FIB4 >1.30 -------REFER TO SECONDARY CARE

FIBROSCAN

Lindsay Horobin
Hepatology Nurse Specialist

NHS
Barnsley Hospital
NHS Foundation Trust

PROUD to learn

WHAT IS A FIBROSCAN

- It's a Non-invasive quick and painless bedside test to measure the elasticity of liver tissue (or liver scarring), referred to as fibrosis
- Provides enormous benefits to patients as in many cases there are no signs or symptoms of mild, moderate or severe liver disease
- Uses an ultrasound probe to measure the speed of a vibration passing through the liver. (the faster the wave the stiffer the liver)
- Takes 15-20 minutes (often less)
- Carried out in Medical Outpatients currently by Hepatology Nurse Specialist
- Results given to patient on same day and lifestyle advice given and either discharged back to GP or referred for further management such as 6 monthly HCC surveillance
- There can be some limitations with a liver fibroscan test.
  - Obesity
  - Liver inflammation
  - Ascites
  - Biliary obstruction
  - Liver congestion
  - Scar tissue

PATIENTS THAT WILL BENEFIT FROM A FIBROSCAN

- People with potential recognised risk factors for liver disease
  - A history of excess alcohol intake
  - Diabetes
  - Obesity
- People who have evidence of a liver condition where there is a need to work out severity
  - Metabolic Dysfunction Associated Steatotic Liver disease (MASLD) (Fatty Liver)
  - Alcohol related Liver Disease (ArLD)
  - Hepatitis B / C
  - Autoimmune Liver Disease
  - Primary Biliary Cholangitis
  - Primary Sclerosing Cholangitis
  - Haemochromatosis
  - Monitoring of patients on medication which may potentially cause liver damage

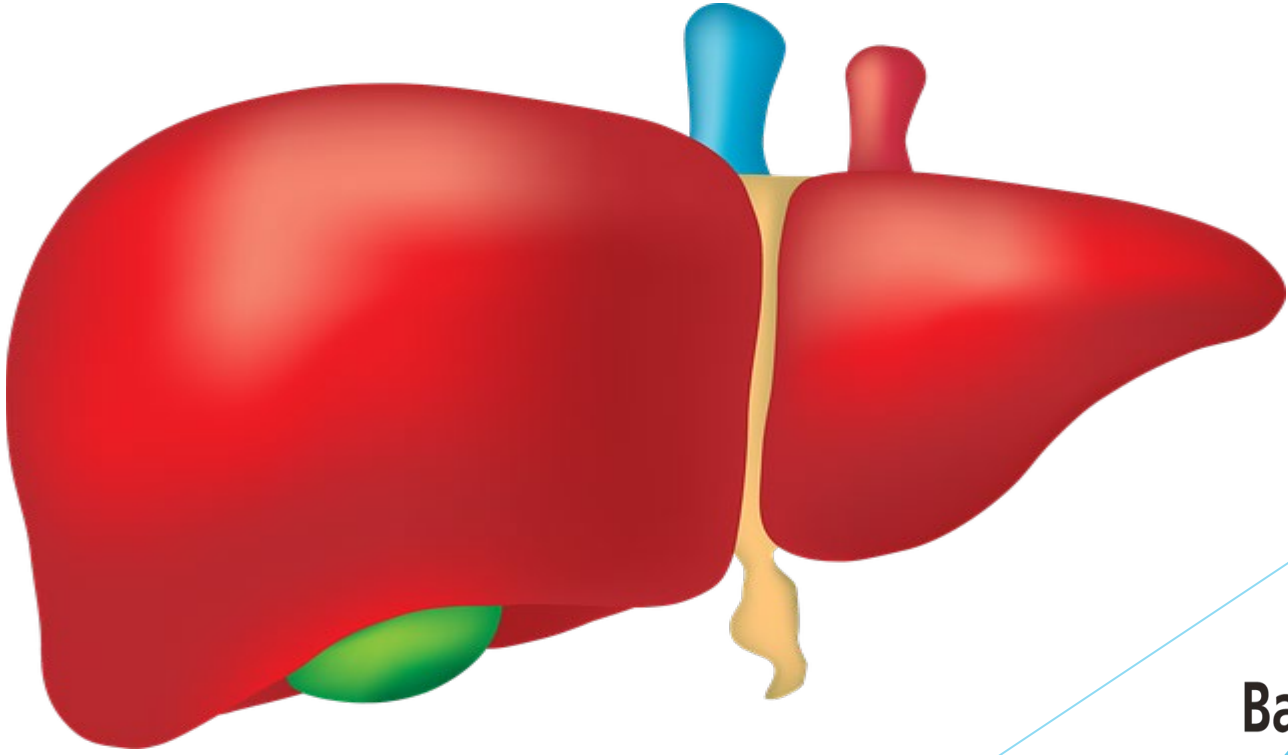
WHAT IS A NORMAL FIBROSCAN SCORE

- A fibroscan score is recorded as a numerical value
- The stiffer the liver the higher the numerical value will be
- A fibroscan score is a numerical result ranging between 2-75kPa
- A normal fibroscan range is approximately 2-8.5kPa
- Scarring of the liver is measured by five stages
  - F0 = no scarring
  - F1 = mild scarring
  - F2 = Moderate Fibrosis
  - F3 = Severe Fibrosis
  - F4 = Advanced fibrosis or cirrhosis

FURTHER MANAGEMENT FOLLOWING A FIBROSCAN

- F0 / F1 Fibrosis = Fibroscan score <7kPa normal liver no further management in secondary care required, discharged back to GP
- F2 Fibrosis = Fibroscan 7 – 8.5kPa indicates mild scarring, lifestyle advice given, no further management in secondary care required, discharged back to GP
- F2 / F3 fibrosis = Fibroscan 8.5 – 10.5kPa indicates moderate scarring, lifestyle advice given, repeat fibroscan in 12 months (organised by secondary care)
- F3 /F4 Fibrosis = Fibroscan 10.5kPa and above –indicates severe scarring / Advanced fibrosis, lifestyle advice given and commenced on 6 monthly HCC surveillance (organised by secondary care)

THANKYOU FOR LISTENING
ANY QUESTIONS ?



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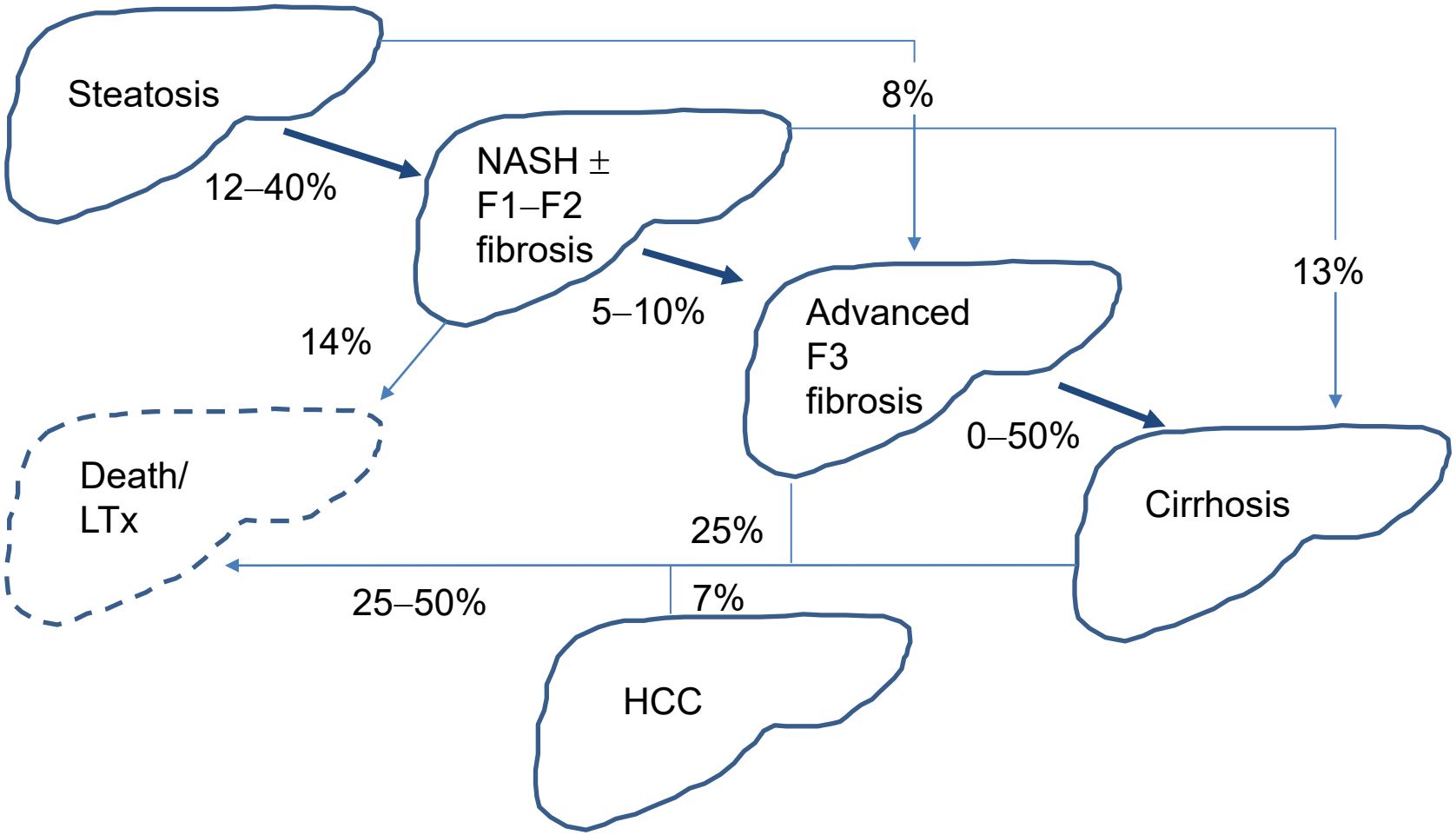
MASLD

- Metabolic dysfunction Associated Steatotic Liver Disease
- Change in terminology from NAFLD
- 17-46% of all adults in Western countries
- Commonest diagnosis in the Hepatology clinic
- Fast becoming the leading cause for liver transplant worldwide
- Metabolic risk factors

Natural history of NAFLD over 8–13 years



de Alwis NMW, Day CP. J Hepatol 2008;48:S104–12

Management of MASLD

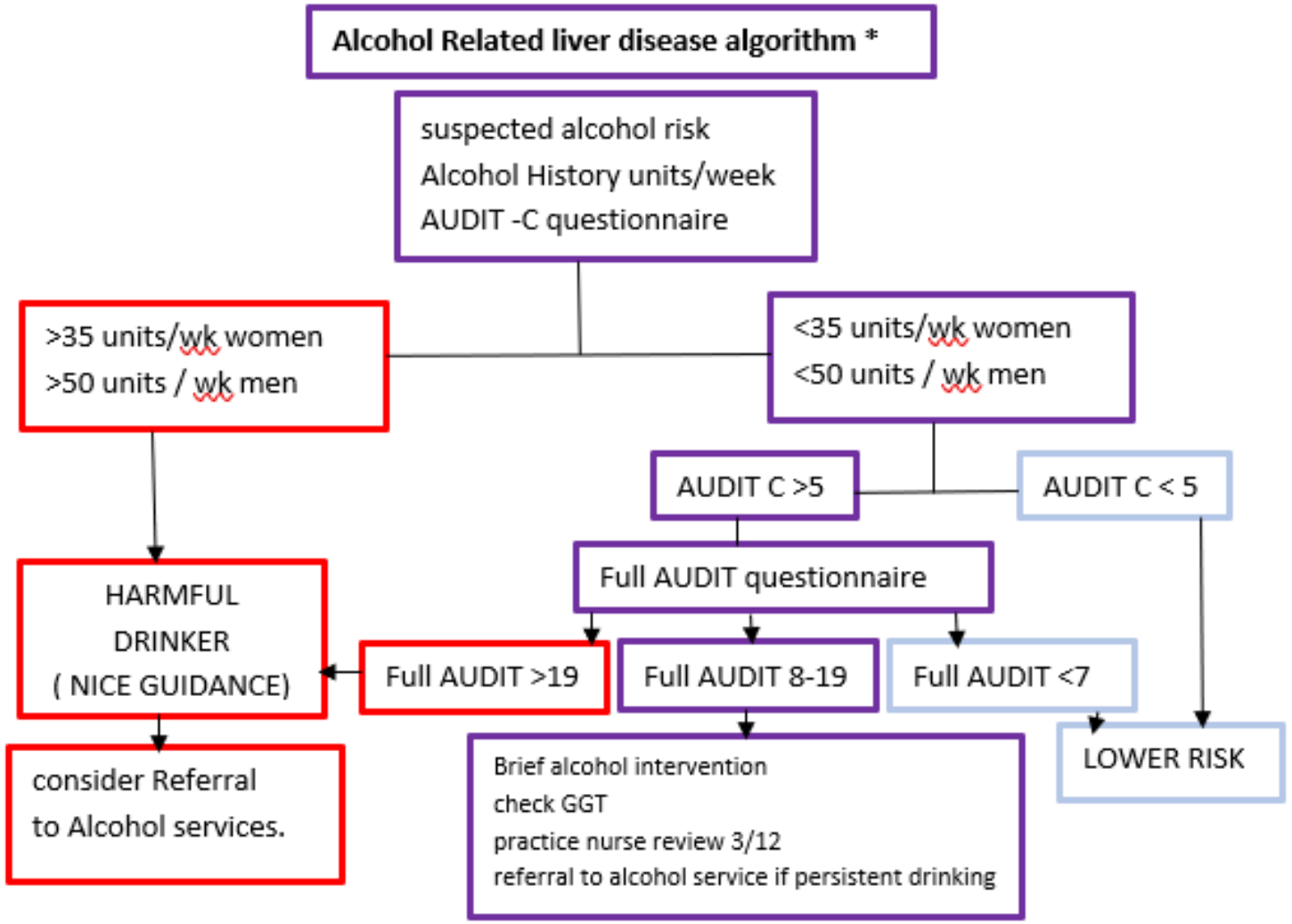
- Lifestyle changes
- Optimization of risk factors
- Advice re: alcohol
- Consider referral to Tier II weight loss programmes
- NO PHARMACOTHERAPY CURRENTLY LICENSED
    - GLP-1 Agonists
    - Pioglitazones
    - Vitamin E

Haemochromatosis

- Raised transferrin saturation is needed for diagnosis
- Autosomal recessive for C282y
- Elevated ferritin should prompt full iron profile
- Ferritin is an acute phase reactant
- Is commonly elevated in MASLD, Alcohol excess

Alcohol related Liver Disease ArLD

- Worldwide, harmful use of alcohol is associated with:
  - ~3.3 million deaths every year [1]
    - 5.9% of all deaths overall (7.6% in men, 4.0% in women)[1]
  - ~139 million disability-adjusted life years
    - 5.1% of the global burden of disease and injury
- Alcohol has an impact on over 200 diseases and types of injuries
- Most deaths attributable to alcohol consumption from:
  - Cardiovascular diseases
  - Injuries
  - Gastrointestinal diseases
    - Mainly cirrhosis
  - Cancers



REFER IF FIB4.1.30 OR ANYONE WHO IS CLASSED AS HARMFUL DRINKER

Viral Hepatitis

- Hepatitis B
  - After acute infection ~90% spontaneous resolution
  - ~9% remain Hepatitis B surface antigen positive
  - Will need long-term follow up in Secondary care
  - Core antibody remains positive for the rest of lifetime
  - No follow up needed

Viral Hepatitis contd..

- Hepatitis C
  - Risk factors include IVDU (past or present)
  - Screening test Hepatitis C antibody
  - If positive, HCV RNA is needed to determine if active infection
  - Hep C antibody positive for the rest of their life

Autoimmune liver disease

- Autoimmune hepatitis
  - ANA, ASMA, Raised IgG
  - 70-80% are women
  - Rarely can present with decompensation

- Primary Biliary CHOLANGITIS and NOT CIRRHOSIS
  - Anti mitochondrial antibody positive with M2 pattern
  - IgM raised

Services provided in Hepatology at BHNFT

- Two full-time Liver Consultants
- Four doctor-led clinics/week
- Dedicated Hepatology A&G and Referral pathways
- One full-time Specialist Liver nurse
- Fibroscan
- Outreach clinics at Burleigh Court
- Ambulatory paracentesis on PIU
- Venesections on PIU

- Open to questions/comments

Cytosponge

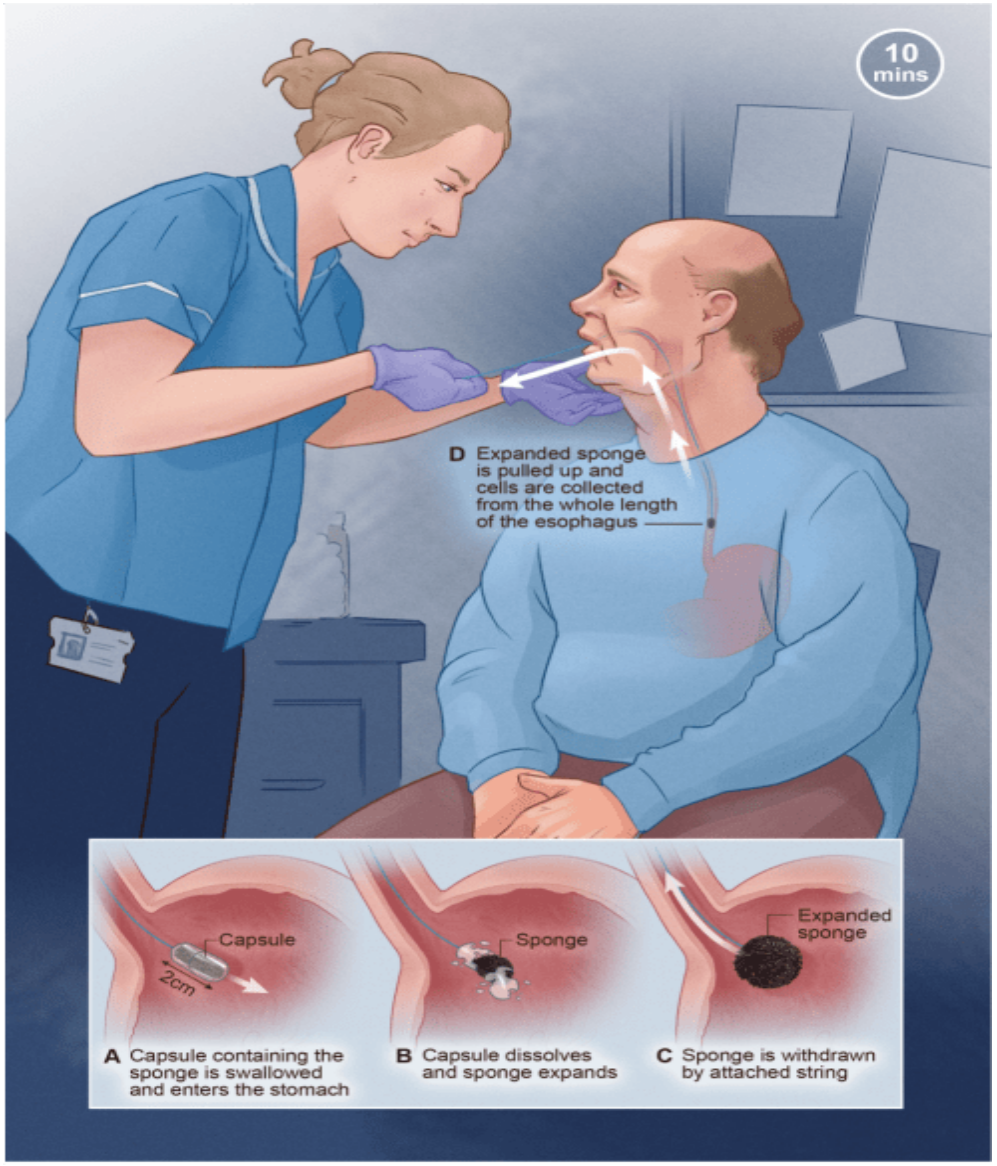
BY STACEY OLIVER

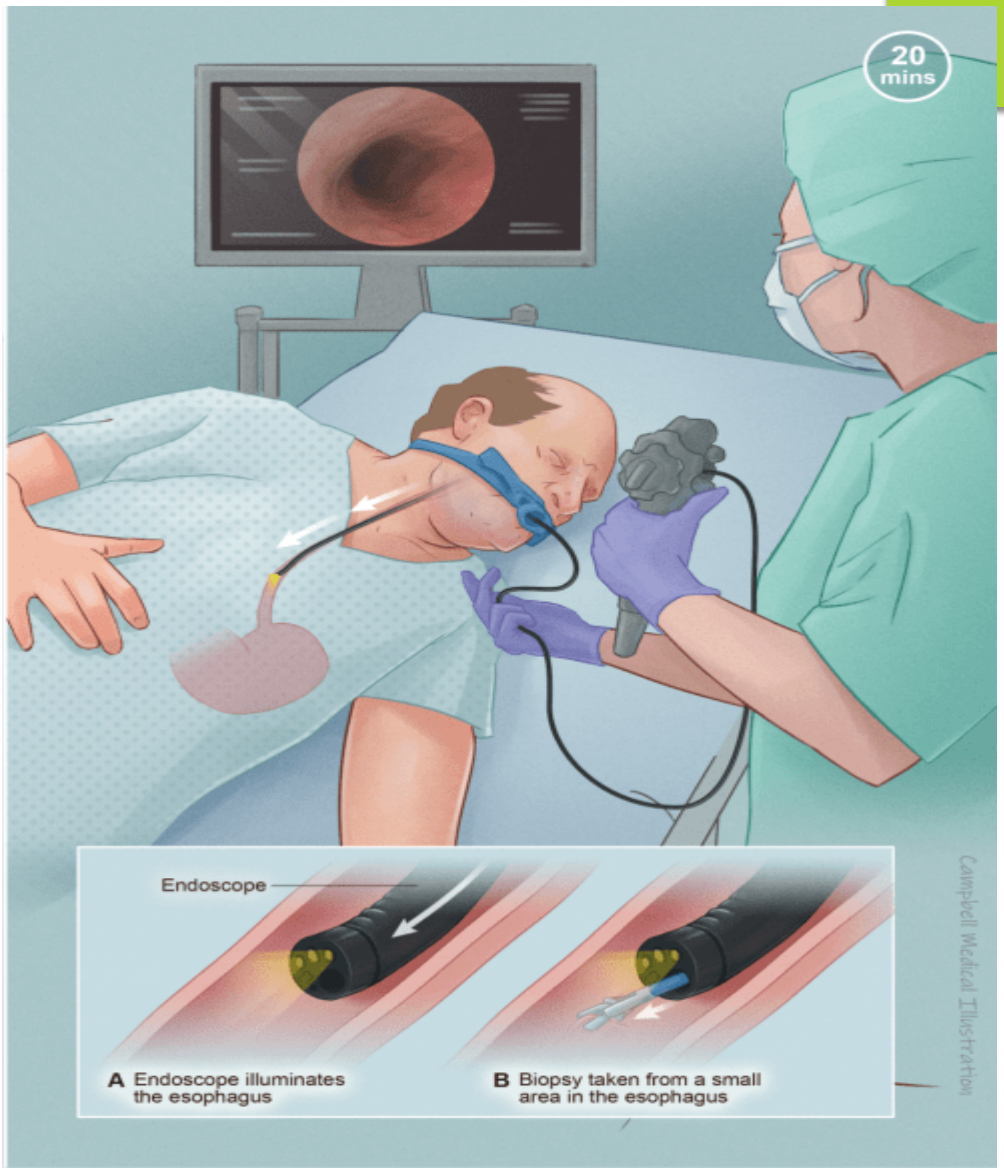
What is Cytosponge

- It is known a ‘Sponge on a string’ pill test.
- Cytosponge consists of a spherical sponge in a dissolvable capsule, which is attached to a thread.

Cytosponge

The Cytosponge cell collection device is indicated for use in the collection and retrieval of surface cells in the Oesophagus for histological analyses.
Cytosponge IFU


10 mins
D Expanded sponge is pulled up and cells are collected from the whole length of the esophagus
Capsule
2cm
Sponge
Expanded sponge
A Capsule containing the sponge is swallowed and enters the stomach
B Capsule dissolves and sponge expands
C Sponge is withdrawn by attached string


20 mins
Endoscope
A Endoscope illuminates the esophagus
B Biopsy taken from a small area in the esophagus
Campbell Medical Illustration

Indication for Cytosponge

Patient Group

- Barrett's surveillance
- Reflux

When was Cytosponge introduced?

- Cytosponge was introduced during the Covid 19 pandemic.
- NHS England Trials carried – to help reduce capacity within endoscopy department. This will minimise the number of upper GI endoscopy procedures required for those at low risk for which endoscopy can be delayed or in some cases avoided. (These slots can be utilised for other patient's in more urgent need)
- Detection of early cancers

Development of the service

- The cytosponge service will run along side the capsule endoscopy service, providing minimally invasive procedures to patient's.
- The patient's will be vetted by the CNS to ensure Cytosponge is a appropriate investigation
- A pre procedure telephone consultation will be offered to discuss cytosponge as a alternative investigation
- The clinics will be nurse led and over seen by a Gastroenterology Consultant.
- The service will be run from the CDC as a diagnostic alternative to OGD for appropriate patient's
- Pathological assessments of the cytosponge samples will be carried out centrally by the company Cyted. The cost of the procedure and pathological assessment per patient is approx. £ 270

Continue

- Results will be analysed by the Gastroenterology consultant or the CNS
- A Results clinic appointment will be given to patient's and they will be informed of any further follow up plan.
- Alternate Sponge then OGD will be the surveillance pathway to ensure safety netting.

Who Can refer?

- Secondary care
- Primary care can refer for consideration for Cytosponge

(This may change as research evolves)

Clinical Evidence

- The Cytosponge test is well-tolerated with high specificity (92%) and sensitivity (80%, higher for clinically significant findings) Kadri et al. 2010, Ross-Innes et al. 2015

- American College of Gastroenterologists states, "…a swallowable, non endoscopic capsule sponge device combined with a biomarker is an acceptable alternative to endoscopy for screening for BE in those with chronic reflux symptoms and other risk factors "

  Shaheen et al 2022 Cytosponge Real World Data Endoscopy Bottlenec

- The Cytosponge can be used as a triage tool for endoscopy to identify people at risk of oesophageal cancer NICE MedTech Innovation Briefing 2020

Current Guidelines and recommendations

- Cytosponge has recently been endorsed by the American and European gastroenterological guidelines. (Currently reviewing BSG and NICE guidance following recent trials)

Benefits

- Nurse led service 1 nurse in a clinic setting
- Minimally invasive for patient's
- Service provided from the CDC
- Releasing endoscopy slots to be utilised for patients on other upper GI pathways
- Reducing endoscopy waiting lists.
- More environmentally friendly

Time for a short break ….

General Medical Council

Implementing *Good medical practice* 2024

Rachel Ball
Regional Liaison Adviser – Yorkshire & Humber

https://www.hellomynameis.org.uk/

GMC Outreach

Regional and national

Improve understanding

Promote and support excellence

Teaching and engagement workshops

In person and online

Gather and share insight

What do we do?


Education
Registration
Standards
Revalidation
Fitness to practise

Good medical practice

Protecting children and young people

Confidentiality

0-18

Decision making and consent

Leadership and management

Raising and acting on concerns

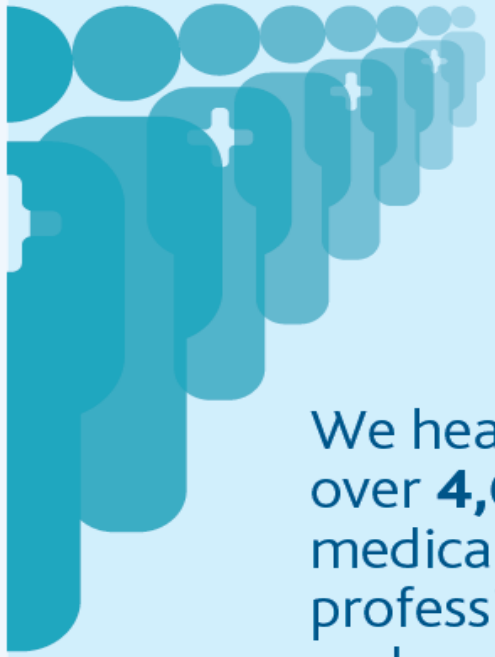
General Medical Council

Good medical practice is at the heart of UK healthcare. It sets the standards of care and professional behaviour expected of all medical professionals registered with us.

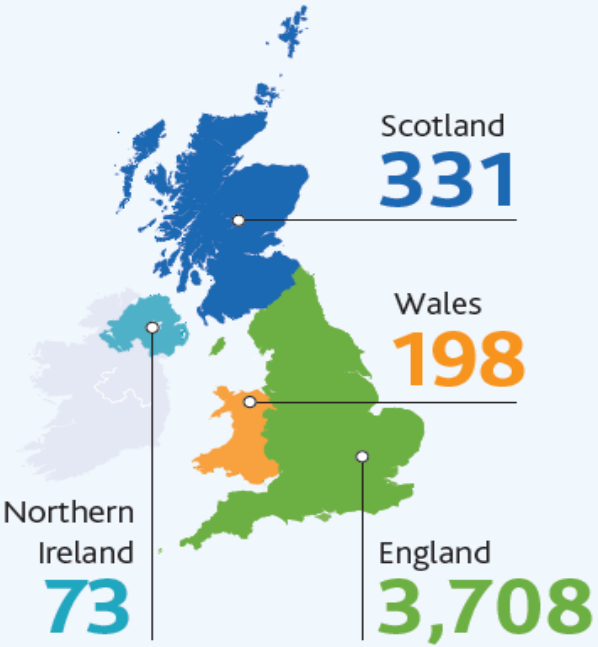
The consultation

General Medical Council

Our consultation on *Good medical practice*



We heard from over **4,600** medical professionals and members of the public



29% of **medical professionals** who responded **qualified outside UK and Europe** (roughly the same proportion as on our medical register).

General Medical Council

Aims of the session:

To explore the key updates to our standards

To consider responsibilities of all doctors in the implementation of Good medical practice

General Medical Council

The four domains

Good medical practice 2024

- Fairness
- Remote consultations
- Making sustainable decisions
- Research

Good medical practice 2024

- Treating patients with kindness, courtesy and respect
- Partnership working
- Meeting communication needs
- Safeguarding

Good medical practice 2024

- Contributing to a positive environment
- Tackling discrimination
- Team working and delegation
- Leadership

Good medical practice 2024

- Acting with honesty and integrity
- Maintaining professional boundaries
- Communicating as a professional
- Managing conflicts of interest

General Medical Council

The professional standards, revalidation and fitness to practise

The professional standards describe good practice, and not every departure from them will be considered serious.

The five key themes:

A new approach?

Five key themes of *Good medical practice 2024*

Good medical practice 2024

1. Creating respectful, fair and compassionate workplaces
2. Promoting patient centred care
3. Helping to tackle discrimination
4. Championing fair and inclusive leadership
5. Supporting continuity of care and safe delegation

Implementing the standards

Creating respectful, fair and compassionate workplaces

48. You must treat colleagues with kindness, courtesy and respect.

51. You must be compassionate towards colleagues who have problems with their performance or health. But you must put patient safety first at all times.

52. You must help to create a culture that is respectful, fair, supportive, and compassionate by role modelling behaviours consistent with these values.

53. You should be aware of how your behaviour may influence others within and outside the team.

What are you doing in your workplace that contributes to a positive culture?

Promoting patient centred care

Promoting patient centred care

32 You must take steps to meet patients' language and communication needs, so you can support them to engage in meaningful dialogue and make informed decisions about their care. The steps you take should be proportionate to the circumstances, including the patient's needs and the seriousness of their condition(s), the urgency of the situation and the availability of resources.

40 If a patient is taking multiple medications, you should discuss the importance of regular reviews to check that the medications continue to meet the patient's needs and are optimised for them. You should consider the overall impact of the patient's treatments, and whether the benefits outweigh any risk of harm.

What helps create a patient centred approach where you work?

Tackling discrimination

Helping to tackle discrimination

56. You must not abuse, discriminate against, bully, or harass anyone based on their personal characteristics, or for any other reason. By ‘personal characteristics’ we mean someone’s appearance, lifestyle, culture, their social or economic status, or any of the characteristics protected by legislation – age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation

57. You must not act in a sexual way towards colleagues with the effect or purpose of causing offence, embarrassment, humiliation or distress. What we mean by acting ‘in a sexual way’ can include – but isn’t limited to – verbal or written comments, displaying or sharing images, as well as unwelcome physical contact.

The bystander duty

Good medical practice 2024

3. Helping tackle discrimination

Good medical practice 2024

Life experience, culture, beliefs

- Interactions
- Decisions
- Patient care

How do you raise awareness about discrimination where you work?

Championing fair, inclusive leadership

4. Championing fair and inclusive leadership

Good medical practice 2024

- Support colleagues through **mentoring, coaching**, teaching or training
- **Fair access** to training, development and employment opportunities
- Taking active steps to create environment where it's safe to
  - Talk about errors
  - Raise concerns
  - Ask questions
- Dealing promptly and adequately with concerns

> "Supportive cultures and inclusive leadership are the most important drivers of compassionate care, and key for the future sustainability of the workforce."
>
> **Charlie Massey**
>
> GMC Chief Executive

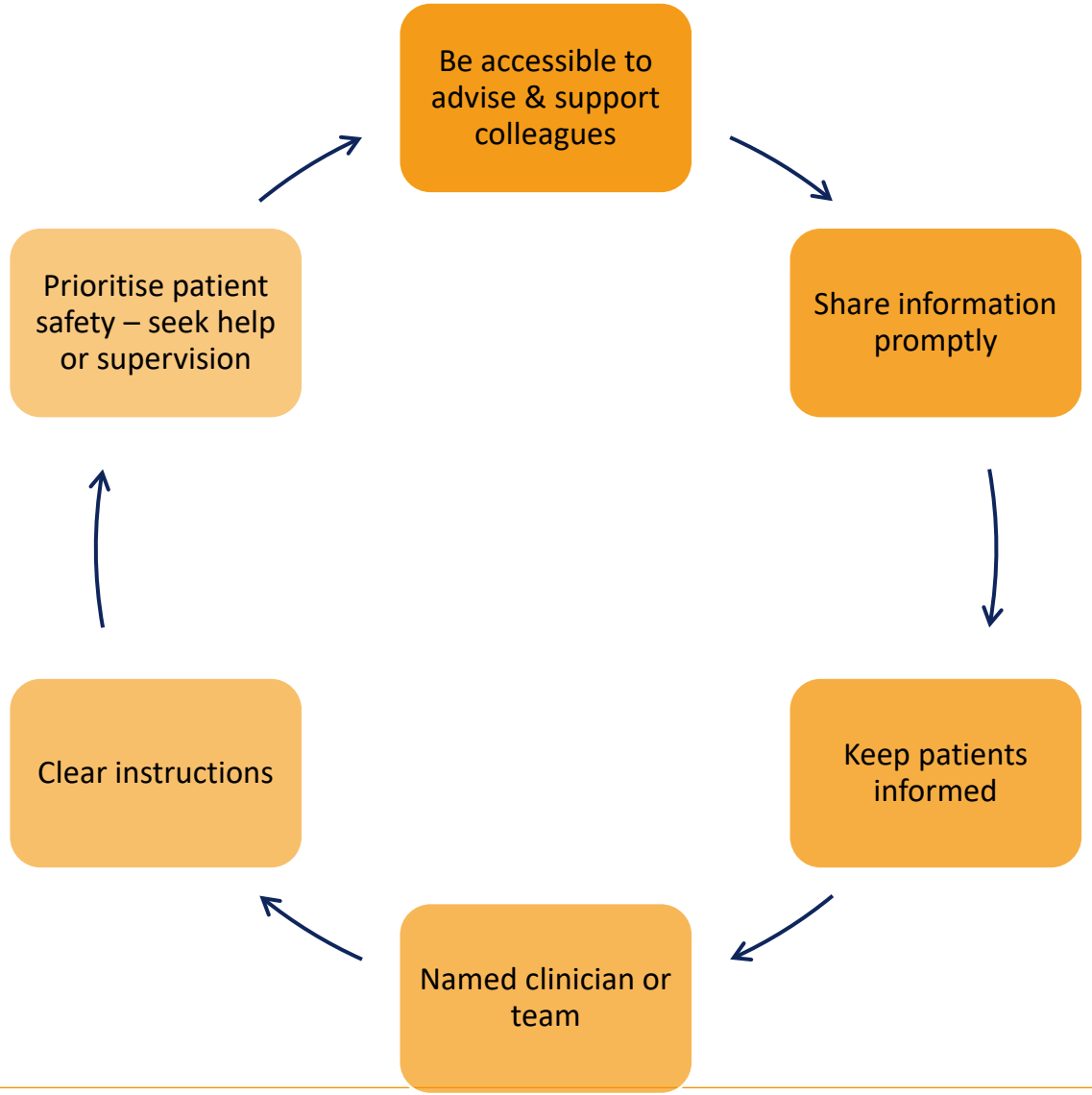
What can support Doctors to be more confident to raise concerns and talk about errors to support learning?

Supporting continuity of care and safe delegation

66. You must be confident that any person you delegate to has the necessary knowledge, skills and training to carry out the task you're delegating. You must give them clear instructions and encourage them to ask questions and seek support or supervision if they need it.

67. If a task is delegated to you by a colleague but you're not confident you have the necessary knowledge, skills or training to carry it out safely, you must prioritise patient safety and seek help, even if you've already agreed to carry out the task independently.

5. Supporting continuity of care and safe delegation



How *Good medical practice* relates to GMC investigations

The professional standards describe good practice, and **not every departure** from them **will be considered serious**.

When a concern is raised, the GMC must assess if there is a **current and ongoing risk** to one or more of the three parts of public protection.

To assess risk the GMC consider:

- how **serious** the concern is
- relevant **context** including system factors
- the doctor's **response** including evidence of **insight** and **remediation**

Good medical practice 2024

How we can support you

GMC ethical hub content

- Racism in the workplace - GMC (gmc-uk.org)
- Speaking up - ethical topic - GMC (gmc-uk.org)
- Identifying and tackling sexual misconduct - ethical topic - GMC (gmc-uk.org)

Home - GMC (gmc-uk.org)

General Medical Council

Questions / comments

professionalstandards@gmc-uk.org

General Medical Council

Regional Liaison Adviser

Rachel.Ball@gmc-uk.org

@gmcuk

0161 923 6602: GMC Contact Centre

0161 923 6399: GMC Confidential Helpline

Please scan the QR code to complete feedback on the meeting and receive your CPD attendance certificate – QR codes to scan can also be found on your table

BEST

Barnsley Education Support and Training

Next Event Wednesday 20th March 2024