variables collected were: age, sex, HCV/HIV coinfection, genotype (G), degree of fibrosis (F), previous treatments, basal viral load (BVL), treatment duration, viral load at 12 weeks post-treatment, adherence and adverse effects (AEs). Effectiveness was evaluated according to SVR12.

Results Ninety-one patients (57.1% men) received treatment with DAAs, with a mean age of 55.6 ± 10.4 years; 20 (22%) were coinfecting with HIV, and 55 (60.4%) had BVL >800 000 IU/mL. The genotype distribution was: 29 (31.9%) G1a, 28 (30.8%) G1b, 1 (1.1%) G2, 15 (16.5%) G3 and 18 (19.8%) G4. Degree of fibrosis: 27 F0–F1, 16 F1, 10 F2, 15 F3, 2 F3–F4 and 14 F4; 7 (7.7%) patients were without data (WD). There were 75 (82.4%) naive patients; 6 had received treatment with DAAs (2 with two different lines).

Treatment distribution was: 36 (39.6%) glecaprevir/pibrentasvir, 28 for 8 weeks and 8 for 12 weeks; 29 (31.9%) elbasvir/grazoprevir, 28 for 12 weeks and 1 for 16 weeks; 23 (25.3%) sofosbuvir/velpatasvir for 2 weeks, 2 with ribavirin; 1 (1.1%) ledipasvir/sofosbuvir for 8 weeks; 2 (2.2%) sofosbuvir/velpatasvir/voxilaprevir for 12 weeks, both after relapse to two previous lines with DAAs.

The response observed was: glecaprevir/pibrentasvir 32 SVR12, 3 WD and 1 treatment suspension because of the patient's poor clinical condition; elbasvir/grazoprevir 26 SVR12 and 3 WD; sofosbuvir/velpatasvir 17 SVR12, 3 WD, 1 died (sepsis) and 2 virological failure (VF) (both G3, 1 F3, 1 F4, 1 relapsed to DAAs); ledipasvir/sofosbuvir: 1 SRV12; sofosbuvir/velpatasvir/voxilaprevir 2 SRV12. Of the total evaluable responses ($n=80$), 78 (97.5%) SRV12 and 2 (2.5%) VF were observed.

Conclusion and relevance Our data confirm the effectiveness of the new DAAs, with SVR12 >95%, and are consistent with clinical trials which show that patients with G3 have the worst SVR12 rates.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-002 ANTICHOLINERGIC BURDEN IN CONSTIPATED PATIENT ADMITTED TO AN EMERGENCY DEPARTMENT

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Background and importance Intestinal obstruction and constipation are frequent causes of attendance at the emergency services. Multiple studies have linked a high anticholinergic burden with constipation in elderly patients. However, its impact on patients attending the emergency department has not yet been clearly established.

Aim and objectives To evaluate the anticholinergic burden in patients who come to the emergency services for constipation, as well as its impact on re-attendance to these units.

Material and methods This was a retrospective observational study. Patients who consulted the emergency department for constipation or intestinal subocclusion were included (September 2018–June 2019). Drugs were collected from the electronic prescription. The anticholinergic burden of the medication was calculated using the anticholinergic burden index scale.¹

A multivariate analysis was performed, including in the model parameters with a value of $p < 0.2$ in the previous univariate analysis. The impact of continuous laxative treatment at discharge on the risk of re-attendance was evaluated. Statistical analysis was carried out using Stata V.2.0.

Results A total of 104 patients were included (mean age $77.1 (\pm 14.6)$ years): 47 patients (56.6%) were classified as having a high cholinergic burden, 30 (36.1%) an intermediate burden and 6 (7.2%) a low burden.

In the univariate analysis, the variables associated with readmission at 30 days were age >80 years, women, diabetes, residence destination, dementia and high cholinergic burden.

In the multivariate analysis, age >80 years (0.34 (0.12–0.97)), a high anticholinergic burden (4.21 (1.07–16.5)) and dementia (3.26 (1.11–9.50)) were associated with readmission after 30 days.

Laxative prescription at discharge in the high burden group patients was not associated with a reduction in re-attendance (OR (95% CI) 0.86 (0.48–3.27)). In the intermediate burden group, a reduction in income was observed (OR (95% CI) 0.13 (0.015–0.99)).

Conclusion and relevance A high anticholinergic burden at discharge from the emergency department in elderly patients who consult for constipation was closely related to re-attendance at 30 days. Hence these patients must be considered high risk and specific interventions established.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-003 LIRAGLUTIDE IN CHRONIC INTESTINAL FAILURE: OVERVIEW AND CASE REPORT

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Background and importance Chronic intestinal failure (CIF) is a rare pathology, included in the 2013 Orphanet list. Parenteral nutrition is a lifesaving and often lifelong therapy because of nutrients loss and electrolyte and fluids imbalance related to impairment in intestinal absorption and high daily stoma output. Antimotility and antisecretory drugs can reduce faecal output and promote better nutrient and fluid absorption. An impaired hormonal 'ileo-colonic brake' may further worsen imbalance in patients with end jejunostomy short bowel syndrome (SBS-IF). Intestinal adaptation can occur in the remaining part of the bowel through secretion of gut trophic peptide hormones, such as glucagon-like peptide (GLP) 2 and 1. With large enteral resections, GLP secretion is virtually absent, and treatment with GLP analogues could be useful. Liraglutide is a GLP-1 analogue which reduces gastric hypersecretion and slows gastric emptying. In an open label, 8 week pilot study, liraglutide significantly reduced the ostomy wet weight output by 474 ± 563 g/day ($p=0.049$).

Aim and objectives The primary aim of the study was to evaluate the effect of liraglutide on faecal output in patients with SBS-IF and a high faecal output.