Table 1 (*Continued*)

Variable	SVR n=209	Without-SVR n= 13	*p*	OR (95%CI)
Basal characteristics				
Episodic hepatic encephalopathy, n (%)				
Persistent hepatic encephalopathy, n (%)	28 (13.4)	5 (38.5)	0.03*	2.9 (1.3-6.2)
History of spontaneous bacterial peritonitis, n(%)	4 (1.9%)	1 (7.7)	0.26	4.0 (0.5-33.4)
Follow-up at 1-year after DAA therapy				
Child-Pugh, points	6±2	9±3	0.007*	-
MELD, points	10.9±3.5	17.3±6.2	0.003*	-
Transition elastography, KPa	23.2±11.6 (n=62)	45.7±20.8 (n=9)	0.01*	-
Variceal bleeding, n (%)	26 (12.4)	7 (53.8)	0.001*	4.3 (2.3-8.0)
Ascites, n(%)	32 (15.3)	9 (69.2)	<0.0001*	4.5 (2.8-7.3)
Episodic hepatic encephalopathy, n (%)	22 (10.5)	7 (53.8)	<0.0001*	5.1 (2.7-9.7)
Persistent hepatic encephalopathy, n (%)	6 (2.9)	3 (23.1)	0.01*	8.0 (2.3-28.6)
Spontaneous bacterial peritonitis, n (%)	0 (0)	1 (7.7)	0.06*	0.9 (0.8-1.1)
Mortality rate, n(%)	1 (0.5)	4 (30.8)	<0.0001*	64.3 (7.7-534.9)

https://doi.org/10.1016/j.aohep.2021.100610

STUDY OF CONCORDANCE BETWEEN THE DEGREE OF LIVER FIBROSIS ESTIMATED THROUGH APRI AND FIB-4 BIOCHEMICAL SCORES, AND ELASTORESONANCE IN PATIENTS WITH AUTOIMMUNE HEPATITIS

P.D. Flores Rangel, N.A. Bolaños Gómez, L.A. Murrieta González, A.B. Craviotto Rivera, E. Cerda Reyes

Central Military Hospital, México City, México

Introduction and Objectives: Autoimmune hepatitis is a chronic and progressive necroinflammatory disease with a fluctuating course of activity and affects more frequently the female sex. The etiopathogenesis is still unknown and may be the result of an interaction between factors: genetic, immunological, autoantigens; Therefore, the interaction of genetic predisposition with an environmental trigger and the disorder in immunoregulation would result in chronic inflammation of the hepatocytes and with it the development of hepatic fibrosis. Diagnostic tests for the evaluation of liver fibrosis include liver biopsy and non-invasive elastographic methods, such as transition elastography and elastoresonance, as well as serum biomarkers, composed of different variables that help predict the degree of liver fibrosis.

Objective: Compare the concordance between the results obtained for the diagnosis of liver fibrosis by the APRI and FIB-4 score, with the elastoresonance, in patients with HAI.

Material and methods: Elastoresonance, APRI and FIB-4 were performed in 6 patients to assess the concordance between different degrees of fibrosis.

Results: A total of 6 patients with a recent diagnosis of HAI were included in the study. The mean age was 50.33 years and 100% were women. 66.66% of the patients presented an advanced degree of fibrosis (F2-F3-F4) due to elastoresonance. The values for the APRI index were: 3 patients (50%) had an advanced degree of fibrosis, 1 patient had a low degree of fibrosis (6%) and 2 patients (33.33%) had intermediate. The findings for the FIB-4 values were exactly the same. The agreement of elastoresonance in the different degrees of fibrosis against the APRI and FIB-4 score was 100%.

Discussion: Non-invasive methods to measure the degree of liver fibrosis in patients with chronic liver disease have shown to be useful, and in this study, it transcends that the correlation with the degree of fibrosis obtained by elastoresonance with the APRI and FIB-4 scores is 100%, this could avoid reaching the liver biopsy, which although it is the gold standard in measuring the degree of liver fibrosis, is an invasive and expensive method, which involves risks for the patient (puncture of other internal organs, infection and adverse reaction to contrast material).

Conclusions: In patients classified with advanced fibrosis, the concordance between the estimates obtained using the elastoMR and those derived from the APRI and FIB-4 scores are high. However, a limitation of this study is the size of the sample.

The authors declare that there is no conflict of interest.

https://doi.org/10.1016/j.aohep.2021.100611

GLUCOGENOSIS AS A CAUSE OF INTRAHEPATIC CHOLESTASIS

K.Y. Santoyo López, A Domínguez García

IMSS Hospital General de Zona 3. Aguascalientes, Mexico

Introduction and Objectives: Hepatic glycogen storage pathologies are very rare diseases among inborn errors of metabolism caused by the alteration of the enzymes involved in the metabolism of glycogen. GSDs are classified according to enzyme deficiency and affected tissue, including types 0, Ia, Ib, III, IV, VI, and XI. The clinical presentation can be very varied, including intolerance to fasting, growth retardation and hepatomegaly. It can present with hypoglycemia, hyperlactatemia, increased liver enzymes, and hyperlipidemia. The most common type of glycogen storage disease is GDS IX, its incidence is 1: 100,000 births and it is responsible for 25% of all cases. The most common GSD IX subtype is subtype IX a caused by mutations in PHKA2, which accounts for 75% of cases. Long-term complications include liver adenomas, kidney disease, cardiomyopathy, and muscle symptoms.

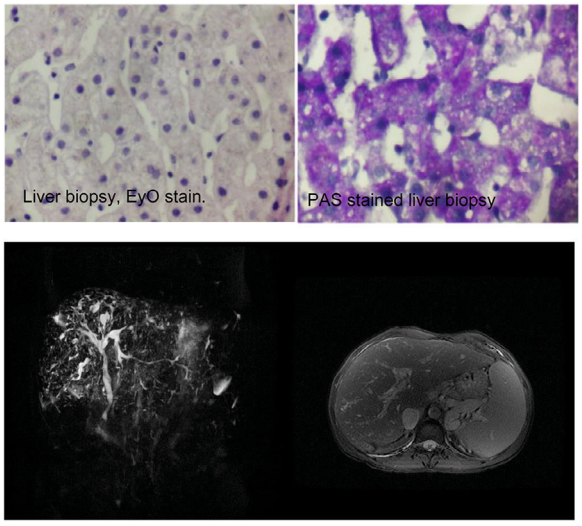
Clinical case: 27-year-old male patient. Important history, positive smoking with IT 1, positive alcoholism with consumption of 8 grams of alcohol per day for 10 years. During childhood, he presented hepatomegaly and an isolated event of jaundice. He began his condition one month before with asthenia, adynamia and weight loss (9 kg / 30 days), accompanied by generalized jaundice, later he presented abdominal pain in the right upper quadrant, with early satiety, acholia and choluria. On physical examination: hepatosplenomegaly, jaundice of the skin and integuments. Paraclinical: BT: 5.3 mg / dl, BD: 1.2 mg / dl 8, DHL: 444IU / L, TGP: 89 U / L, TGO: 168 U / L FA: 1050 U / L. HIV: non-reactive, HBV HCV non-reactive. Ultrasound with multiple nodular echogenic lesions without bile duct dilation, a 1.8 mm common bile duct, a 7 mm portal vein, and an enlarged spleen. Endoscopy: portal hypertensive gastropathy, extrinsic compression of the body and gastric fundus without evidence of varicose veins. Cholangioresonance without intra- and extra-hepatic bile duct dilation. Normal alpha 1 antitrypsin (2.08 g / dl). Given the evidence of intrahepatic cholestasis, it was decided to perform an ultrasound-guided liver biopsy where it was observed positive for intracytoplasmic glycogen in the hepatocytes, thus establishing a definitive diagnosis of Glycogenosis.

Discussion: Due to its low incidence, the diagnostic approach of Glycogenosis presents a challenge. The diagnosis is made at an early

age; the clinical data will depend on the affected tissue and type of Glycogenosis. The histopathological report is the mainstay of diagnosis in this type of case and making a differential diagnosis with other entities and a genetic study.

Conclusions: Glycogen storage disorders are part of a group of rare and few suspected pathologies. It is not frequent to find them in adult patients due to their complications. The prognosis must be individualized based on the affected tissue and the subtype presented.

The authors declare that there is no conflict of interest.



Collagioresonance

https://doi.org/10.1016/j.aohep.2021.100612

ADDRESSING THE INFILTRATIVE PATTERN: COMPLEX DIAGNOSIS

A.L. Ordóñez-Vázquez, J. Prieto-Nava, F. Ayala-Ochoa, A. Heredia-Jara, L. Montiel-Velázquez, I. López-Méndez

Fundación Clínica Médica Sur, Gastroenterology and Obesity Clinic. Mexico City, Mexico

Introduction and objective: Alterations in liver function tests are frequent, so the approach based on the predominant alteration and the patient's medical history is relevant. Carrying out a liver biopsy in cases of diagnostic doubt is imperative. The objective of this work is to describe a clinical case of an infiltrative pattern approach that culminated in the diagnosis of Hepatosplenic T-cell Lymphoma (HSCTL).

Patients and Methods: Clinical case report. Presentation. Woman, 72 years old. History of a sister with cirrhosis. Consumption of alcohol and herbalists; arterial hypertension and Sjögren. He was admitted for persistent fatigue and jaundice. Laboratories with anemia, thrombocytopenia and kidney injury; Hepatic biochemistry with a predominantly cholestatic pattern at the expense of alkaline phosphatase and direct hyperbilirubinemia. Without acute liver failure. By imaging the liver, vessels and normal bile duct; splenomegaly; Negative hepatitis viral panel, positive ANAs and Anti-actin, negative antimitochondrials, normal immunoglobulins. HAI vs. DILI / HILI is suspected. Liver biopsy reports HSTCL-type lymphoproliferative process (Figure 1). It was supplemented with bone marrow aspirate and PET-CT. He started prednisone and cyclophosphamide.

Discussion: The systematic approach to altered liver biochemistry requires integrating personal and family risk factors for liver disease. The infiltrative pattern that resembles the cholestatic one represents a diagnostic challenge as it is little recognized. In this case, we report a rare neoplasm corresponding to 5% of peripheral T lymphomas; they usually develop in young adults and in the absence of lymphadenopathy. It also has an adverse prognosis due to refractoriness to chemotherapy.

Conclusion: The HSTCL presented in this clinical case represents a complex and infrequent diagnosis. The symptoms and age group were atypical and the identification was possible through a systematic evaluation of the infiltrative pattern and differential diagnoses.

The authors declare that there is no conflict of interest.

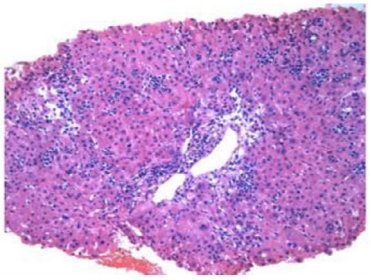


Figure 1. Atypical lymphocyte infiltrate in liver parenchyma.

https://doi.org/10.1016/j.aohep.2021.100613

PRIMARY BILIARY CHOLANGITIS COMPLICATED WITH ULCERATIVE COLITIS: A CASE REPORT

J.C. Valles Gonzales[1], O. García Rodas[1], N. Pérez y López[1], C.A. Hernández Cuevas[2]

[1] *Gastroenterology Department, Hospital Juárez de México, Secretaría de Salud, México City, México*
[2] *Pathology Department, Hospital Juárez de México, Secretaría de Salud, México City, México*

Introduction and Objectives: Liver involvement is not unusual in patients with inflammatory bowel disease (IBD), where one third of patients have abnormal liver biochemical tests, becoming a diagnostic challenge. Primary biliary cholangitis (CPB) is an autoimmune liver disease that presents with chronic cholestasis, the presence of specific antibodies and histological findings of destructive non-suppurative cholangitis. Genetic, immunological, and environmental factors that contribute to the pathogenesis of IBD may also contribute to associated hepatobiliary disorders. Objective: Present the case of a 67-year-old woman who consulted for cholestatic symptoms. Medical record of smoking for 25 years was suspended 15 years ago with a smoking index of 5. She reported a history of weakness, asthenia, self-limited palmar and plantar pruritus of 2 years of evolution, associated with abnormal liver function tests (total bilirubin 1.8 mg / dl, INR 1.40, albumin 3.2 g / dL). The initial physical examination revealed jaundice in the sclera, palmar erythema, evidence of telangiectasia in the abdomen, collateral circulation with medusa caput, positive ascitic wave, and splenomegaly. R factor is cholestatic, with alkaline phosphatase of 416 U / L, gamma glutamyl transpeptidase 660 U / L, alanine transferase 59 U / L, for which possible viral and autoimmune causes are addressed as the first possibility, reflecting antimitochondrial antibodies with high titers (278 U / L), associated with immunoglobulin G of 2490 mg / dl and immunoglobulin M of 734 mg / dl. During her one-year follow-up, she reported the onset of diarrheal stools Bristol 6, 2 to 3 episodes per day, with occasional urgency and with inflammatory characteristics, due to the presence of mucus and blood. Infectious causes are ruled out, elevated acute phase reactants are reported, followed up with a colonoscopy and