patients in follow-up, 19 decompensated at least once (6 ACLD) and 18 died. In 3/19 (15.8%) IgG a-HEV was detected; however, only one of them (1/3) seroconverted 13 months after the start of the study, while the other two patients had detectable IgG a-HEV antibodies from the beginning of the study. Nevertheless, in these three individuals, the presence of IgM and HEV RNA was not detected.

Conclusions: Our study shows a higher prevalence of IgG a-HEV in the group of cirrhotic patients compared to the control group. However, no association was found between HEV infection and the decompensation events observed in the analyzed cohort.

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P- 62 PREDICTION OF FIBROSIS PROGRESSION AND CLINICAL OUTCOMES WITH NON INVASIVE TESTS IN 10 YEARS FOLLOW UP OF PATIENTS WITH NON ALCOHOLIC STEATOHEPATITIS

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Introduction and Objectives: Fibrosis stage is the most important prognostic factor in non-alcoholic fatty liver disease (NAFLD). Although liver biopsy is the gold standard for staging fibrosis, it is a difficult tool to use on follow-up evaluations. Non-invasive tests (NITs) were developed to first stratify patients at risk for advanced fibrosis but were not validated for follow-up. This study aimed to evaluate liver fibrosis progression, NITs variations over time and their correlation with clinical outcomes (hepatic decompensation, hepatic and extra-hepatic neoplasm; cardiovascular events and mortality).

Materials and Methods: Retrospective cohort of 138 patients with biopsy proven non-alcoholic steatohepatitis (NASH). Patients underwent clinical, physical, and laboratory examinations and NIT assessments (FIB-4 and transient elastography - TE). Fibrosis progression was estimated using TE. NIT variations over time were compared with the development of clinical outcomes.

Results: 138 patients were analyzed. The median age was 65 years and the median body mass index was $32Kg/m^2$ at diagnosis. Seventy-seven patients (55%) had diabetes and 82 (59%) had hypertension at diagnosis. Fifty-six patients (40%) had advanced fibrosis ($\geq$F3) and 18 (13%) of them had cirrhosis at biopsy. The median time of follow-up was 10 years. One hundred nineteen patients performed TE at the end of the follow-up. Fifty-nine patients progressed to cirrhosis (49,6%). Initial NAFLD activity score (NAS) was statistically associated with fibrosis progression. Twenty-four patients (17%) developed a clinical outcome. The fibrosis stage at diagnosis was associated with cirrhosis decompensation but not associated with cardiovascular events. Fibrosis progression assessed with elastography (>11,5kPa) was associated with portal hypertension development. FIB-4 elevation during follow-up (>2,7) was associated with cirrhosis decompensation.

Conclusions: High-risk NAFLD patients have a high prevalence of fibrosis progression and clinical outcomes. NITs such as FIB-4 and TE might be useful tools for the evaluation of disease progression and risk of hepatic decompensation. More prospective studies are needed to better define NITs cut-offs for risk of clinical outcomes.

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P- 63 TREATING HEPATITIS C (HCV) IN ADDICTION CENTERS IN OUR COMMUNITY: ANOTHER STEP TOWARDS MICROELIMINATION

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Introduction and Objectives: To achieve the WHO objective of eliminating Hepatitis C by 2030, we must implement new strategies to reach difficult-to-treat patients. Basque Health Department-Osakidetza is implementing a project called "Action lines for the prevention and control of hepatitis C in the Basque Country." One of the strategies adopted is the treatment of people who have used intravenous drugs in Addiction Centers (AC), which simplifies access to diagnosis and treatment.

Materials and Methods: We actively looked for HCV-infected patients through database cross-checking. We identified the patients in AC of our community since January 1, 2019, and we crossed this list with HCV serological studies carried out by Osakidetza. Thus, we have identified three groups of patients: a) HCV-RNA+, b) HCV Ab+, without HCV-RNA determination, and c) patients not tested for HCV, candidates for study and treatment.

Results: We have identified 178 people who had already been treated or had cleared infection spontaneously; another two were not treated due to terminal illness and pharmacological interaction; nine patients had died, 16 were coinfected with HIV and sent to Infectious Department and nine had abandoned our community. We finally have identified and treated in the AC 22 patients (all of them have achieved SVR), and 20 more patients to test and treat, if positive.

Conclusions: :
Between the time of preparation of this strategy and its performance, which was delayed due to the pandemic, many patients had already been referred to hospitals and treated there.

1. This gives us an idea of the awareness of psychiatrists about the importance of detecting and treating Hepatitis C in this group of patients.

2. Adherence to treatment was very high and SVR was 100%.

3. Treating patients in AC allows us to reach difficult-to-treat populations.

4. The initiative was very well accepted by patients.

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P- 64 HEPATITIS C VIRUS MICRO-ELIMINATION PROGRAM IN AN OPEN POPULATION

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Introduction and Objectives: Among the WHO, goals for 2030 are to detect >90% of people with HCV and link >80% to treatment. Our institution serves an open population without social security. This study aimed to describe the detection strategy that was carried out in the open population, using two-step HCV detection tests at "Hospital General de México" from January to December 2021.