[1] *Gastroenterology Section, Internal Medicine Department, Clinic Hospital of University of Chile, Santiago, Chile*
[2] *"Dr. Victor Rios Ruiz" Health Care Complex, Los Ángeles, Chile*
[3] *Critical Patient Unit, Medicin Department, Clinic Hospital of the University of Chile, Santiago, Chile*

Introduction and Objectives: Patients with nonalcoholic fatty liver disease (NAFLD) are at increased cardiovascular risk, and there is a higher prevalence of this disease in patients with coronary heart disease (CHD). However, the evidence in favor of NAFLD as a risk factor for CHD is scarce. This study aimed to determine the prevalence of NAFLD in patients with CHD and to assess whether significant CHD is associated with NAFLD and liver fibrosis.

Materials and Methods: Observational, analytical study in adult patients with coronary angiography for suspected coronary artery disease between July 2021-July 2022. The number of affected coronary vessels and the presence of significant CHD (stenosis >50%) were determined. In addition, FibroScan® was performed to evaluate steatosis and liver fibrosis up to 6 months after the coronary study, considering the presence of fibrosis at F>0. Descriptive statistics, Fisher's exact test and logistic regression models were reported for inferential analysis.

Results: Ninety-seven patients were included, 73% male, age 63 ± 10 years (Table 1). 71% presented significant CHD, with 37% multivessel disease (2 or more). The prevalence of NAFLD was 38%, with no differences between those with and without CHD (43% vs. 36%, p=0.646). In turn, 16% of patients presented some degree of fibrosis, linearly associated with the number of vessels involved (OR=1.8, p=0.022), with an even higher risk in patients with two or more vessels involved (OR=3.5, p=0.027).

Conclusions: There is a high prevalence of NAFLD in patients with CHD, with no differences between patients with significant stenosis vs not. Patients with multivessel disease have higher odd of presenting some degree of fibrosis. Although the presence of confounders should be evaluated in other studies, these data support the search for NAFLD and fibrosis in patients with CHD.

Table 1. Characterization of the patients included in the project

N = 97	N (%)
Sociodemographic	
Age (media, SD)	62.8 (10.1)
Male gender	72 (74)
Medical history	
Comorbidities	
Hypertension	73 (75)
Diabetes Mellitus 2	36 (38)
Dyslipidemia	54 (56)
Other	32 (33)
Smoking habit	
Non-smoker	50 (51)
Active smoker	13 (13)
Former smoker	34 (36)
Physical activity	33 (34)
Laboratory (median, IQR)	
Glycemia (n = 83)	108 (94 – 121)
Platelets (n = 88)	231500 (194500 – 275500)
Albumin (n = 78)	4 (3,6 – 4,4)
Cholesterol (n = 87)	153 (118 – 180)
Triglycerides (n = 69)	138 (100 – 216)
Alkaline phosphatases (n = 81)	86 (72 – 97)
GPT (n = 25)	31 (22 – 49)
GOT (n = 83)	31 (25 – 40)
GGT (n = 24)	36.5 (24.95 – 84.5)
Bilirubin (n = 82)	0.57 (0.44 – 0.74)
Anthropometry	
Body Mass Index (median, IQR)	27.5 (25.3 – 30.1)
Waist circumference (median, IQR)	98.5 (92 – 105)
Hip circumference (median, IQR)	102 (97 – 107)
Fibroscan	
kPa (median, IQR)	4.6 (4 – 5.4)
CAP (media, SD)	258.6 (54.4)
Fibrosis	
F0	81 (84)
F1	9 (9)
F2	3 (3)
F3	2 (2)
F4	2 (2)
Steatosis	
Without steatosis	47 (48)
Mild	13 (13)
Moderate	6 (6)
Severe	31 (32)
Coronariography	
Significant Coronary Heart Disease	69 (71)
N° coronary vessels affected	
1	34 (35)
2	16 (16)
3	20 (21)

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O-15 INFECTIONS BY MULTI-DRUG RESISTANT BACTERIA WERE INDEPENDENTLY ASSOCIATED WITH HOSPITAL MORTALITY IN CIRRHOTICS WITH ACUTE DECOMPENSATION: A PROSPECTIVE STUDY ON 433 ADMISSIONS

Gabriela Ruffillo[1], Juan Cruz Codd[1], Limbert Jesús Padilla Martínez[1], Miguel Angel Puga Tejada[1], Adriana Fernández Lausi[2], Graciela Landeira[1], Graciela Priore[2], Cristina Longo[1], Gisela Gualano[1], Nora Domínguez[1], Maximiliano Socas[1], Susana di Bartolomeo[2], Eduardo Fassio[1]

[1] *Gastroenterology Department, Hospital Nacional Prof. Alejandro Posadas National Hospital, El Palomar, province of Buenos Aires, Argentina*
[2] *Central Laboratory Service, Prof. Alejandro Posadas National Hospital, El Palomar, Province of Buenos Aires, Argentina*

Introduction and Objectives: It has been described as bacterial infections (BIs) due to multidrug-resistant bacteria (MRB) in cirrhosis with acute decompensation (AD), with a potentially poor prognosis. This study aimed to determine the frequency of BIs due to MRB in a tertiary centre and its association with mortality.

Materials and Methods: This is a prospective cohort study. Cirrhotics with AD were enrolled. At admission, polymorphonuclear leukocytes (PMN) count was performed in ascites patients. Blood, urine and fluids cultures were collected in patients with encephalopathy, ascites, digestive bleeding or because of IBs suspicion. Sample cultures were repeated during hospitalization when necessary. BIs diagnosis was established based on international consensus. Association among data versus BIs diagnosis was assessed through respective hypothesis testing. Data association with mortality was verified through univariate/multivariate logistic regression: Odds Ratio (OR), 95% confidence interval (CI).

Results: A total of 433 inpatients were included: 327 males, median age of 56. Child-Pugh A, B and C were estimated in 22, 197, and 214 cases, respectively, median MELD of 16. BIs were diagnosed in 212/433 (49%) inpatients: 128/212 community-acquired (CA) infections, 22/212 healthcare-associated (HCA) infections and 62 nosocomial infections. The most frequent BIs were spontaneous bacterial peritonitis in 69/212 cases, followed by 59/212 respiratory tract

infections and 29/212 urinary tract infections. Bacterial isolation was obtained in 108/212 BIs: 35/108 (32.4%) were MRB. MRB was more frequent in cases with HCA (53%) and nosocomial (41%) infections compared with CA (22%) infections; (*P*=.0279). Mortality was 17.6% in patients without BIs, 28.8% in non-isolation BIs, 24.7% in non-MRB BIs and 51.4% in BIs due to MRB (*P*<.001). Multivariate analysis showed that mortality was significantly associated with Child-Pugh C, acute kidney injury, but mainly with MRB BIs (OR 4.41; 95% CI 1.94-10.2; *P*<.001).

Conclusions: MRB frequency was 32.4% among BIs with bacterial isolation. It represents an independent predictor for inpatient mortality.

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O-16 MELD-NA AND MELD3.0 HAVE THE BEST PERFORMANCE TO PREDICT THE 28-DAY RISK OF DEATH IN PATIENTS WITH SEVERE ALCOHOLIC HEPATITIS IN THE MEXICAN POPULATION

Fátima Higuera-De La Tijera[1], Claudia Dorantes-Nava[1], Alfredo Servín-Caamaño[2], Francisco Salas-Gordillo[1], Juan Miguel Abdo-Francis[3], Gabriela Gutiérrez-Reyes[4], P Diego-Salazar[1], MY Carmona-Castillo[1], Sandra Teutli-Carrion[1], EJ Medina-Avalos[1], A Servín-Higuera[1], José Luis Pérez-Hernández[1]

[1] *Gastroenterology and Hepatology Department, Mexican General Hospital "Dr. Eduardo Liceaga", México City*
[2] *Internal Medicine Department, Mexican General Hospital "Dr. Eduardo Liceaga", México City*
[3] *Ángeles Acoxpa Hospital, México City*
[4] *Liver, Pancreas And Motility Laboratory (HIPAM), Experimental Medicine Department, Faculty Of Medicine, Unam; Mexico City*

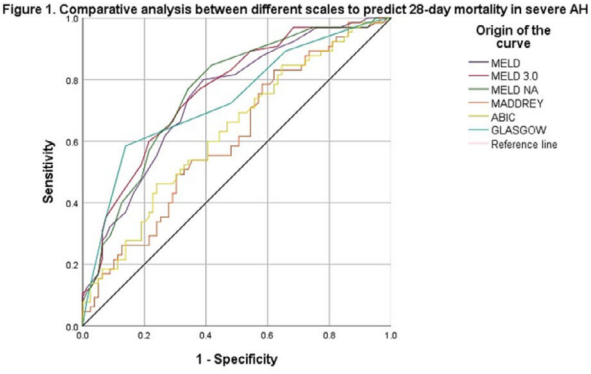
Introduction and Objectives: Severe alcoholic hepatitis (AH) has a high mortality rate, and currently, it is still a challenge to be able to establish the prognosis of these patients and their risk of death at admission in order to be able to offer better therapeutic alternatives that save a life in a timely manner. This study aimed to compare several prognostic scores to verify which of them has the best performance in predicting 28-day mortality at admission in patients with AH.

Materials and Methods: Observational, cohort study. Data were collected from patients with severe AH who were hospitalized between January 2010 to May 2022. MELD, MELDNa, MELD3.0, ABIC, Maddrey, Glasgow scale for AH were calculated with admission parameters, and their outcome was verified at 28 days. ROC curves were constructed to compare the different prognostic scales.

Results: 144 patients were included, 129 (89.6%) men, mean age 43.3±9.3 years, median grams of alcohol consumed/day were 320 (range: 60-1526). 65 (45.1%) died. The mean of MELD, MELDNa and MELD3.0 were higher among the deceased vs. survivors (33.5±7.5 vs. 27.1±6.2; 34.6±5.7 vs. 29.1±5.7; and 35.8±6.0 vs. 30.1±5.5 respectively; p<0.0001). The ROC curve analysis comparing the prognostic scales is shown in Figure 1.

Conclusions: AH mortality is high. MELDNa and MELD3.0 have the best performance for predicting on admission which patients with AH are at risk of dying in the next 28 days and can be useful tools for prioritizing patients who will require life-saving strategies, such as liver transplantation.

Figure 1. Comparative analysis between different scales to predict 28-day mortality in severe AH



Diagonal segments are generated by ties.

Scale	Area under the curve	95% confidence interval	*P*
MELD	0.743	0.663 - 0.823	< 0.0001
MELD 3.0	0.760	0.682 - 0.838	< 0.0001
MELDNa	0.761	0.682 - 0.839	< 0.0001
Maddrey	0.611	0.519 - 0.702	0.023
ABIC	0.630	0.539 - 0.721	0.007
Glasgow	0.735	0.652 - 0.818	< 0.0001

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O-17 STUDY OF THE ASSOCIATION BETWEEN SERUM LEVELS OF SYSTEMIC INFLAMMATORY MARKERS AND ADVANCED FIBROSIS STAGE IN INFECTED PATIENTS WITH HEPATITIS DELTA VIRUS GENOTYPE 3

Mauricio Campos[1], Juan Miguel Salcedo[4], Deusilene Vieira[4], Songeli Freire[1], Raymundo Paraná[1,2], María Isabel Schinoni[1,2,3]

[1] *Institute of Health Science. Federal University of Bahia. Bahía. Brazil*
[2] *Universitary Hospital of Federal University of Bahia. Bahía. Brazil*
[3] *Medical School of Bahia. UFBA. Bahia. Brazil*
[4] *Oswaldo Cruz Foundation (FIOCRUZ) of Rondônia, Brazil*

Introduction and Objectives: HDV-3 is responsible for outbreaks of fulminant hepatitis in northeastern South America. There are no studies investigating immune responses in relation to liver damage caused by HDV-3. This study aimed to investigate if systemic inflammatory molecules (SIM) are differentially expressed in patients with advanced fibrosis chronically infected with HDV genotype 3.

Materials and Methods: 61 patients coinfected with HBV/HDV-3 naive were included in this study. Diagnostic tests to screen for HBV/HDV infections were performed using standard immune serology testing. HDV quantification and genotyping was performed by semi-nested RT-PCR and RFLP methodology. 92 SIMs were measured by Proximity Extension Assay (PEA) technology(Proseek Multiplex Inflammation I assay). Shapiro-Wilk, Student's t test, Mann-Whitney tests and logistic regression analysis were used when appropriate.

Results: The median age was 41 years(18-59 years) and all patients were HBeAg negative. Advanced fibrosis or cirrhosis(F3/F4) was diagnosed by histological staging in 17 patients, while 44 presented with minimal or no fibrosis. Advanced necroinflammatory activity correlated positively with serum levels of AST and ALT (p=0.024 and 0.020, respectively). Established non-invasive fibrosis scores (APRI, FIB-4 and AST/ALT ratio) revealed low sensitivities and PPVs with AUROC maximum of 0.586. Among the 92 SIMs analyzed,