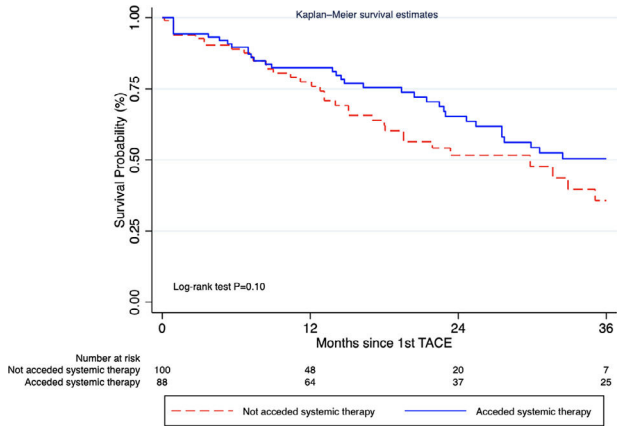
Conclusions: In our region, less than half of HCC systemic treatment candidates acceded to sequential TACE-systemic therapy. Although not statistically significant, due to underpowered estimations, numerically higher survival was achieved with TACE-systemic therapies.

VARIABLE	*Acceded systemic therapy n=88 (46.8%)*	*Not acceded systemic therapy n=100 (53.2%)*	*P values*
Age, years (± SD)	68 ± 9.5	65 ± 9.4	0.04
Gender, Male, n (%)	63 (71.6)	72 (72.0)	0.95
Cirrhosis, n (%)	76 (86.4)	95 (95.0)	0.04
Etiology of liver disease, n (%)			
Viral/non-viral	29 (32.9)/59 (67.0)	38 (38.0)/62 (62.0)	0.47
Hepatitis C	25 (28.4)	33 (33.0)	0.49
Metabolic associated steatotic liver disease	33 (37.5)	29 (29.0)	0.21
Alcoholic liver disease	6 (6.8)	12 (12.0)	0.79
Pre TACE characteristics			
Child Pugh A/B, n (%)	71 (80.7)/17 (19.3)	73 (73.0)/27 (27.0)	0.21
Prior decompensation, n (%)	17 (22.4)	13 (13.7)	0.14
ECOG 0-1, n (%)	87 (98.9)	96 (96.0)	0.22
Median total Bilirubin, mg/dl (IQR)	1.0 (0.7-1.5)	1.2 (1.0-1.6)	0.003
Median Albumin, g/dl (IQR)	3.8 (3.4-4.1)	3.5 (3.2-3.9)	0.008
Median INR, (IQR)	1.1 (1.0-1.3)	1.2 (1.0-1.3)	0.07
Mild/moderate Ascites, n (%)	3 (3.4)	8 (8.0)	0.31
Hepatic encephalopathy, n (%)	3 (3.4)	2 (2.0)	0.48
Median number of HCC nodules, (IQR)	2 (1-3)	2 (1-3)	0.61
Median serum AFP, ng/ml (IQR)	25.0 (7.4-147)	11.3 (4.2-159)	0.21
AFP ≥400 ng/ml, n (%)	11 (15.1)	16 (20.2)	0.40
BCLC before TACE, n (%)			
0	1 (1.1)	3 (3.0)	0.32
A	23 (26.1)	16 (16.0)	
B	55 (62.5)	70 (70.0)	
C	9 (10.2)	11 (11.0)	
HAP score before TACE, n (%)			
A	32 (36.4)	15 (15.0)	0.003
B	37 (42.0)	45 (45.0)	
C	13 (14.8)	28 (28.0)	
D	6 (6.8)	12 (12.0)	
TACE characteristics			
Median target lesion diameter, mm (IQR)	48.0 (35.5-60.0)	42.0 (31.5-55.0)	0.18
TACE modality, n (%)			
DEB-TACE	39 (47.0)	41 (44.6)	0.60
cTACE	44 (53.0)	49 (53.3)	
Other (TAE, chemoinfusion)	-	2 (2.2)	
Unknown	-	-	
Median number of TACEs	2 (2-3)	2 (1-3)	0.09
Post TACE outcomes			
ORR 1st TACE	49 (55.7)	48 (48.0)	0.29
ORR last TACE	19 (24.7)	22 (31.4)	0.36
Liver decompensation, n (%)	7 (7.9)	- (0)	0.004

Comparison between patients acceding and not acceding to systemic therapies



Survival comparison between patients acceding and not acceding to systemic

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P-33 COMBINATION OF FIB-4 SCORE AND D-DIMER TO PREDICT OUTCOME IN HOSPITALIZED COVID-19 PATIENTS

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Conflict of interest: No

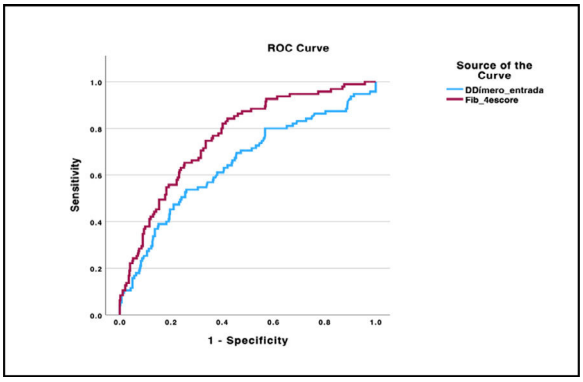
Introduction and Objectives: Identifying risk factors for poor outcomes is crucial for defining treatment strategies and allocating resources in COVID-19. The Fibrose-4 score (FIB-4) and D-dimer (DD) have emerged as prognostic markers; however, precise cutoff points and their combined use remain unstudied. *Objectives:* This study aimed to compare the individual and combined performance of FIB-4 and DD in predicting outcomes among COVID-19 patients.

Patients / Materials and Methods: Materials and Methods: From March to December/2020, hospitalized COVID-19 patients were evaluated regarding laboratory admission tests, chest CT scan, gender, age, lung involvement, ICU admission, hemodialysis, mechanical ventilation, and mortality. Optimal FIB-4 and DD cutoffs to predict in-hospital mortality, aiming to maximize sensitivity and specificity, were established. A sequential diagnostic strategy using both markers was subsequently evaluated.

Results and Discussion: Results and Discussion: Among 518 patients (61±16 years, 64% men), the in-hospital mortality rate was 18%. FIB-4 showed superior performance in predicting mortality compared to DD (AUROC 0.76 *vs.* 0.65, p=0.003) and was chosen as

the first step in sequential analysis. Mortality was higher in patients with FIB-4≥1.76 vs. FIB-4<1.76 (26% vs. 5%, p<0.001) and DD≥2000 ng/mL FEU vs. DD<2000 ng/mL FEU (38% vs. 16%, p<0.001). FIB-4 was used as a screening test, with a cutoff point of 1.76 (90% sensitivity in ROC curve analysis), followed by DD measurement with a cutoff value of 2000 ng/mL FEU (specificity of 90%). Through this approach, a subgroup of patients with a higher mortality rate was identified, compared to the use of FIB-4 alone (48% vs. 26%, p<0.001), missing the identification of only 4.7% of deaths.

Conclusions: The sequential use of FIB-4 and DD represents a comprehensive strategy to identify high-risk COVID-19 patients at hospital admission, potentially minimizing unnecessary DD assessments in patients initially classified by FIB-4 as low-risk for adverse outcomes.



Analyze of the performance of FIB-4 and DD in predicting in-hospital mortality through ROC curve analysis

Table 1. Comparison of primary and secondary outcomes of patients with low and high FIB-4†

	Total (n=518)	FIB-4 < 1.76 (n=191)	FIB-4 ≥ 1.76 (n=327)	p-value
Mortality (n, %)	95 (18%)	9 (5%)	86 (26%)	<0.001
Hospital length of stay (days)	14 ± 17	9 ± 12	16 ± 19	<0.001
ICU‡ admission (n, %)	358 (69%)	120 (63%)	238 (73%)	0.018
ICU length of stay (days)	12 ± 15	8 ± 9	14 ± 17	<0.001
Hemodialysis (n, %)	76 (15%)	7 (4%)	69 (21%)	<0.001
Mechanical ventilation (n, %)	106 (21%)	17 (9%)	89 (27%)	<0.001
Lung involvement on chest CT§ ≥ 50%	67 (13%)	11 (6%)	56 (17%)	<0.001

Abbreviations: †FIB-4, fibrosis-4 score; ‡ICU, intensive care unit; §CT, computed tomography.

Comparison of primary and secondary outcomes of patients with low and high FIB-4

Table 2. Comparison of primary and secondary outcomes of patients with low and high DD†

	Total (n=518)	DD < 2000 (n=454)	DD > 2000 (n=64)	p-value
Mortality (n, %)	95 (18%)	71 (16%)	24 (38%)	<0.001
Hospital length of stay (days)	14 ± 17	13 ± 17	16 ± 16	0.160
ICU‡ admission (n, %)	358 (69%)	301 (66%)	57 (89%)	0.018
ICU length of stay (days)	12 ± 15	12 ± 16	10 ± 10	0.311
Hemodialysis (n, %)	76 (15%)	57 (13%)	19 (30%)	<0.001
Mechanical ventilation (n, %)	106 (21%)	81 (18%)	25 (39%)	<0.001
Lung involvement on chest CT§ ≥ 50%	67 (13%)	45 (12%)	9 (20%)	0.117

Abbreviations: †DD, D-dimer; ‡ICU, intensive care unit; §CT, computed tomography.

Comparison of primary and secondary outcomes of patients with low and high DD

Table 3. Hospital mortality rates according to FIB-4† and DD‡ levels

		Discharge (n=423)	Death (n=95)	p-value
FIB-4 < 1.76	DD < 2000 (n=173)	166 (96%)	7 (4%)	0.203
	DD ≥ 2000 (n=18)	16 (89%)	2 (11%)	
	Total = 191	182 (95%)	9 (5%)	
FIB-4 ≥ 1.76	DD < 2000 (n=281)	217 (77%)	64 (23%)	<0.001
	DD ≥ 2000 (n=46)	24 (52%)	22 (48%)	
	Total = 327	241 (73%)	86 (26%)	
Total (n=518)		423	95	<0.001

Abbreviations: †FIB-4, fibrosis-4 score; ‡DD, D-dimer.

Hospital mortality rates according to FIB-4 and DD levels

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P-34 ALBUMIN-BILIRUBIN GRADE ANALYSIS OF OVERALL SURVIVAL WITH ATEZOLIZUMAB PLUS BEVACIZUMAB IN PATIENTS WITH UNRESECTABLE HEPATOCELLULAR CARCINOMA

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Conflict of interest: No

Introduction and Objectives: Atezolizumab-bevacizumab (atezo-bev) is currently recommended as first-line therapy for patients with unresectable hepatocellular carcinoma (uHCC). However, its effectiveness in patients with albumin-bilirrubin (ALBI) grade 2 has been questioned in a recent post-hoc analysis of the Phase III IMbrave 150 study, which showed that atezo-bev had a similar overall survival (OS) compared to sorafenibe in that population. To evaluate the impact of ALBI grade on OS in patients with uHCC treated as first-line systemic therapy with atezo-bev.

Patients / Materials and Methods: This prospective cohort study was conducted in Hospital de Clinicas de Porto Alegre and Hospital Moinhos de Vento, two tertiary healthcare centers in the city of Porto Alegre, Brazil. It comprised all Child A patients with uHCC that started atezo-bev as first line therapy between August 2020 and May 2023. ALBI grade within 30 days of treatment initiation was calculated using MDCalc, available online free of charge. Mean OS was established for patients with ALBI-1 versus ALBI-2 and 3.

Results and Discussion: A total of 20 Child A patients with uHCC were included, 1 classified as Barcelona Clinic Liver Cancer B (BCLC-B) and 19 as BCLC-C. Mean age was 65 years, 75.6% were males and all were cirrhotic. According to ALBI grade, 10 patients were classified as ALBI-1 and 10 as ALBI non-1 (9 grade 2 and 1 grade 3). Mean OS among those with ALBI-1 was 56.3 weeks and among those with ALBI non-1 was 32 weeks (P<0.05). Macrovascular invasion (MVI) was similar in ALBI-1 vs non-1 (40% vs 50%, respectively). However, variceal bleeding during atezo-bev was remarkably different among ALBI-1 vs non-1 patients (0 vs 50%, respectively).