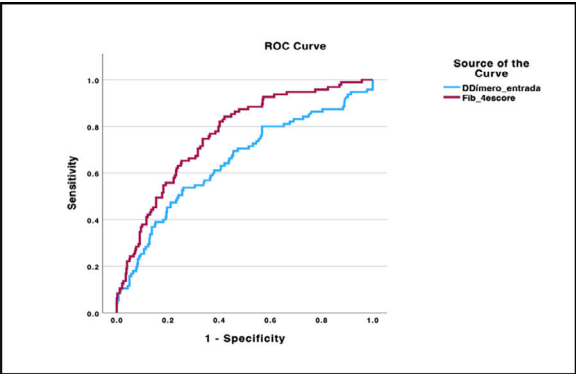


the first step in sequential analysis. Mortality was higher in patients with FIB-4 $\geq$ 1.76 vs. FIB-4<1.76 (26% vs. 5%, p<0.001) and DD $\geq$ 2000 ng/mL FEU vs. DD<2000 ng/mL FEU (38% vs. 16%, p<0.001). FIB-4 was used as a screening test, with a cutoff point of 1.76 (90% sensitivity in ROC curve 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 ^a				
	Total (n=518)	FIB-4 < 1.76 (n=191)	FIB-4 $\geq$ 1.76 (n=327)	p-value
Mortality (n, %)	95 (18%)	9 (5%)	86 (26%)	<0.001
Hospital length of stay (days)	14 $\pm$ 17	9 $\pm$ 12	16 $\pm$ 19	<0.001
ICU ^b admission (n, %)	358 (69%)	120 (63%)	238 (73%)	0.018
ICU length of stay (days)	12 $\pm$ 15	8 $\pm$ 9	14 $\pm$ 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 ^c $\geq$ 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 ^a				
	Total (n=518)	DD < 2000 (n=454)	DD $\geq$ 2000 (n=64)	p-value
Mortality (n, %)	95 (18%)	71 (16%)	24 (38%)	<0.001
Hospital length of stay (days)	14 $\pm$ 17	13 $\pm$ 17	16 $\pm$ 16	0.160
ICU ^b admission (n, %)	358 (69%)	301 (66%)	57 (89%)	0.018
ICU length of stay (days)	12 $\pm$ 15	12 $\pm$ 16	10 $\pm$ 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 ^c $\geq$ 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 ^a and DD ^b levels				
		Discharge (n=423)	Death (n=95)	p-value
FIB-4 < 1.76	DD < 2000 (n=173)	166 (96%)	7 (4%)	0.203
	DD $\geq$ 2000 (n=18)	16 (89%)	2 (11%)	
	Total = 191	182 (95%)	9 (5%)	
FIB-4 $\geq$ 1.76	DD < 2000 (n=281)	217 (77%)	64 (23%)	<0.001
	DD $\geq$ 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-bilirubin (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).

Conclusions: Overall, the findings of this study showed that the baseline ALBI grade was superior to Child score in predicting the prognosis of patients with uHCC treated with atezo-bev.

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P-35 CLINICAL AND EPIDEMIOLOGICAL DIFFERENCES BETWEEN PATIENTS MONOINFECTED WITH HEPATITIS B AND COINFECTED WITH HEPATITIS DELTA IN A HYPERENDEMIC REGION OF HEPATITIS B

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Conflict of interest: No

Introduction and Objectives: Hepatitis B and co-infection with hepatitis delta are viral liver diseases that can rapidly progress to cirrhosis and hepatocellular carcinoma (HCC). *Objectives:* To compare the epidemiological profile between patients mono-infected with hepatitis B and patients co-infected with hepatitis B and delta in a hyperendemic region.

Patients / Materials and Methods: A cross-sectional and historical cohort study analyzing 286 medical records of co-infected individuals and 649 medical records of mono-infected. Variables: sex, age, stage of liver fibrosis, levels of liver enzymes, albumin, platelets, alpha-fetoprotein, presence of HCC, and outcomes (liver transplant or death).

Results and Discussion: Of the 286 co-infected, 189 (70.5%) were male, mean age 56 ± 19 . About stage of fibrosis, 97 (34%) had no fibrosis, 163 (57%) had (F1F3), and 26 (9%) had cirrhosis (F4). Mean GGT were 64.6 ± 86.6 U/L, ALT 36.2 ± 33.1 U/L, AST 41.2 ± 61.1 U/L, albumin 4.1 ± 0.75 g/dL, platelets 192 ± 77 thousand/mm³, alpha-fetoprotein 122.7 ± 181.1 ng/mL. 12 (4.2%) developed HCC, mean age of 53 ± 11.8 ; 8 (2.8%) underwent liver transplantation, and 22 (7.7%) died. Of the 659 mono-infected, 449 (68.14%) were male, mean age 53 ± 12.7 . About stage of fibrosis, 248 (36%) had no fibrosis, 335 (48.69%) had fibrosis (F1F3), and 105 (15.26%) had cirrhosis (F4). Mean GGT were 64.4 ± 85.9 U/L, ALT 36.2 ± 33.8 U/L, AST 40.7 ± 59.9 U/L, albumin 4.19 ± 0.74 g/dL, platelets 3.27 ± 3.4 thousand/mm³, alpha-fetoprotein 117.6 ± 2133.5 ng/mL. 31 (4.7%) developed HCC, mean age of 57.4 ± 12.6 ; 18 (2.7%) died.

Conclusions: Co-infected patients have a higher prevalence of liver fibrosis and develop HCC at a younger age. There was statistical significance in platelet count, indicating greater severity of liver dysfunction in the mono-infected group.

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P-36 THE PROGNOSTIC ROLE OF NEUTROPHIL-LYMPHOCYTE RATIO IN PATIENTS WITH ALCOHOLIC HEPATITIS

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Conflict of interest: No

Introduction and Objectives: The neutrophil-lymphocyte ratio (NLR) has been used as a predictor of survival in critically ill patients. However, there are scarce studies that evaluate the relationship between NLR and alcoholic hepatitis.

To determine the association between NLR with mortality and the degree of acute-on-chronic liver failure (ACLF).

Patients / Materials and Methods: Longitudinal, retrospective, observational and descriptive cohort study of a hospital center. The subjects met criteria for alcohol hepatitis established by the National Institute on Alcohol Abuse and Alcoholism. Patients with concomitant infections or conditions that could alter the NLR were excluded.

Statistical analysis was performed with the SPSS version 26 program. To compare clinical values, Student's T-test or Mann Whitney U test were performed according to the distribution of the data. The association analysis between NLR and 30-day mortality, as well as the association between NLR and ACLF degrees, were carried out using a point-biserial correlation. Cohen's d test was performed to determine the effect size.

Results and Discussion: This study included 58 patients with alcoholic hepatitis (98% men). There was significant difference between patients who died within 28 days compared with those who survived (Table 1). The mean NLR value in patients who survived was approximately three times the value presented in patients who died within 28 days ($p < 0.001$). A gradual increase in severity-dependent NLR was identified based on the CLIF-C ACLF SCORE.

In addition, significant associations between NLR and 28-day mortality ($p < 0.001$), and between NLR and the degree of ACLF ($p < 0.001$) were found. According to Cohen's test, the effect size of the NLR was moderate (0.678).

Conclusions: The association between high NLR levels and mortality within 28 days is confirmed. Furthermore, there is an association between NLR and the severity of ACLF. Therefore, the NLR could be a useful prognostic factor in the clinical practice for alcoholic hepatitis.