Table 1. Comparison of clinical data and severity scales between surviving and non-surviving subjects at 28 days.			
Variable	Death in the first 28 days (n=33)	Survivors after 28 days (n=25)	*p*
Age	46.0 ± 8.7	41.8 ± 10.1	0.094
Leukocytes	21.6 (15.0, 29.6)	9.6 (7.7, 13.2)	< 0.001
Platelets	168.9 ± 97.1	138.8 ± 91.9	0.234
PT	23.0 (19.1, 28.6)	22.2 (17.9, 25.7)	0.236
BT	24.4 ± 9.3	15.0 ± 10.1	< 0.001
INR	2.00 (1.79, 2.70)	1.94 (1.50, 2.27)	0.118
Cr	2.16 (1.30, 3.19)	1.30 (0.82, 2.09)	0.007
NLR	23.0 (18.0, 34.0)	8.0 (5.0, 11.0)	< 0.001
CLIF-C ACLF Score	56.18 ± 6.28	46.88 ± 6.35	< 0.001
MADDREY	71.3 (55.3, 99.1)	65.6 (33.4, 74.5)	0.059
MELD	35.7 ± 12.5	25.0 ± 8.6	< 0.001
MELD NA	39.2 ± 15.8	29.7 ± 13.8	0.021

Abbreviations: *PT: prothrombin time, BT: Total bilirubin, Cr: creatinine, NLR: neutrophil lymphocyte ratio.*

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P-37 ENHANCED DIAGNOSTIC ACCURACY OF FIB-4 WITH M30 FOR IDENTIFYING AT-RISK PATIENTS WITH STEATOTIC LIVER DISEASE

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Conflict of interest: No

Introduction and Objectives: Liver fibrosis is an important prognostic factor in alcohol-associated liver disease (ALD) and metabolic dysfunction-associated steatohepatitis liver disease (MASLD). New drugs in steatotic liver disease (SLD), such as Resmetirom, are indicated in individuals with at least significant fibrosis. Cytokeratin-18 is a hepatocyte cytoskeleton protein that is released during apoptosis in its cleaved form by caspases (M30) and can be used as a non-invasive test (NIT) to stratify liver fibrosis. However, data on its performance is scarce in the Hispanic population. We aim to evaluate the diagnostic performance and additive value of M30 to identify significant fibrosis in a cohort of patients with ALD and MASLD.

Patients / Materials and Methods: We conducted a cross-sectional cohort study of patients with ALD and MASLD who underwent liver biopsy or transient elastography between 2014–2023. The cut-off points for significant fibrosis (F2) and cirrhosis by transient elastography were ≥7.8 and ≥12.5 kPa, respectively. A receiver operator characteristic (ROC) was used to assess the performance of M30 and FIB-4.

Results and Discussion: We included 55 ALD and 43 MASLD patients. The median age was 51 [42–60] years and 70.4% were male. Median liver stiffness was 6.8 [4.6–27.9] kPa and median M30 190.4 [146-274.8] U/l. Around 41.8% had F2 and 33.6% had cirrhosis. FIB-4 outperformed M30 in predicting significant fibrosis (AUROC 0.88 vs. 0.66, p-value=0.007) and cirrhosis (AUROC 0.93 vs. 0.56, p-value<0.001) (Figure 1). Five out of 29 (17.2%) patients had a low FIB-4 (<1.3) but significant fibrosis; in this scenario, M30 correctly identified F2 in 4 (80%) of them. Thus, the misclassification of significant fibrosis was reduced from 5.1% to 1.0% using a stepwise assessment with FIB-4 and then M30.

Conclusions: M30 had limited diagnostic value in detecting liver fibrosis in the Hispanic population, but its use in combination with FIB-4 can identify more patients with significant fibrosis than FIB-4 alone.

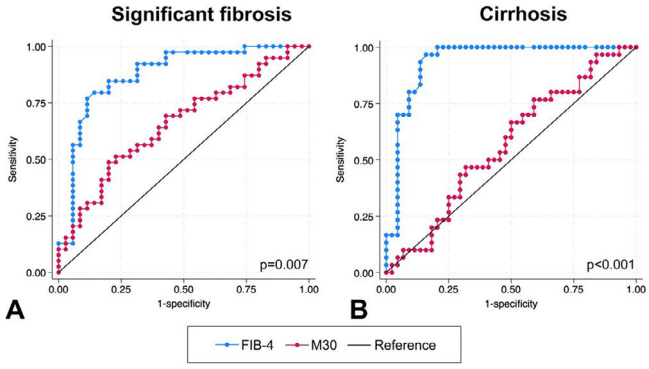

Figure 1. Receiver operator characteristic curves of M30 and FIB-4 to predict significant fibrosis and cirrhosis in a cohort of patients with alcohol-associated liver disease (ALD) and metabolic dysfunction-associated steatohepatitis liver disease (MASLD)

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P-38 EVALUATION OF THE GENETIC AND VIROLOGICAL PROFILE OF PREGNANT WOMEN INFECTED WITH HEPATITIS B AND C VIRUSES IN A REFERENCE CENTER IN RIO DE JANEIRO, BETWEEN 2016 AND 2022

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Conflict of interest: No

Introduction and Objectives: It is estimated that there are around 400 million people living with hepatitis B (HBV) and/or C virus (HCV) infections worldwide. This situation is relevant because both viruses can be transmitted vertically (VT). Despite efforts to prevent VT, many measures still need to be reinforced, especially

regarding the spread of clinically relevant viral variants. Therefore, this study aimed to demonstrate the clinical/laboratory profile of pregnant women identified as positive for HBV and HCV during prenatal care, and referred to a specialized viral hepatitis unit in Rio de Janeiro between 2016-2022, and to identify those with clinically relevant mutations that can be transmitted vertically.

Patients / Materials and Methods: To this end, all pregnant women with positive rapid tests were retested by eletrochemioluminescence using commercial tests for HBV antigens and antibodies against HBV and HCV. In addition, molecular tests were carried out to quantify HBV DNA and/or HCV RNA. Liver enzyme tests were also carried out in order to classify pregnant women according to HBV clinical phase.

Results and Discussion: Two hundred and thirty-two pregnants women with HBV and HCV infection were analyzed. Among the 138 pregnant women with HBV, 95% had HBeAg-negative chronic infection and the mean viral load was 3.70 log IU/ml. Up to now, 6 samples were sequenced, Genotypes A1 (n=5/6,83%) and D3 (n=1/6,16%) were identified and the mutation Y100C was found. In 94 pregnant women with HCV, 75.7% had HCV RNA successfully amplified, with subtypes 1a (n=12/33; 36,4%), 1b (n=17/33; 51,5%) and 3a (n=3/33; 9,1%) detected. Clinically relevant mutations were found V321L, V321IV, C316N.

Conclusions: Identifying mutations in HBV and HCV infections is crucial for epidemiological surveillance and postpartum treatment. Our findings highlight the importance of monitoring drug-resistant mutations in pregnant women with these infections.

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P-39 PREVALENCE AND FACTORS ASSOCIATED WITH TREATMENT ADHERENCE IN LIVER TRANSPLANT PATIENTS ATTENDED AT LACARDIO, BOGOTÁ, COLOMBIA

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Conflict of interest: No

Introduction and Objectives: Patients undergoing liver transplantation need long-term follow-up to ensure graft success and survival. Adherence to lifestyle recommendations and medication, particularly immunosuppressive therapy, is a key factor in graft survival and in reducing public health costs. Adherence impacts graft survival and public health costs. Given its importance and the lack of research in Latin America and Colombia, we assess local adherence levels and explore factors associated with non-adherence. *Objective:* To determine the prevalence of adherence to pharmacological and non-pharmacological treatments and the associated factors among liver transplant patients treated at a tertiary care hospital in Colombia

Patients / Materials and Methods: The BAASIS questionnaire was used to assess adherence among liver transplant patients at a specialized transplant center in Colombia. In addition, ITBS questionnaire was used for the identification of barriers to immunosuppressive medication adherence (external vs. patient-controlled barriers). Demographic and clinical data were collected from 2006 to 2024.

Results and Discussion: In this study, 398 post-transplant patients with a mean age of 49 at transplantation were analyzed. Logistic regression using the BAASIS scale showed 35.1% (140) were non-adherent to their immunosuppressive regimen. The ITBS scale categorized barriers as unintentional (e.g., skipping medications due to travel, depression, or running out) or intentional (e.g., forgetting, side effects, feeling well, or routine deviations). Bivariate analysis revealed a significant association with adherence at a 5% significance level. Pre-transplant follow-up variables also showed links to non-adherence and prior assessments of unsuitability by social work or psychology.

Conclusions: Non-adherence in post-transplant patients is influenced by both intentional and unintentional factors, underscoring the need to address these in pre- and post-transplant education. Special attention should be given to non-adherence histories during pre-transplant evaluations and psychological or social work assessments that deem patients unsuitable at any point. More targeted follow-up and education could significantly reduce non-adherence rates.

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P-40 ASSOCIATION BETWEEN LIVER STIFFNESS MEASUREMENTS USING MR ELASTOGRAPHY AND PORTOSYSTEMIC SHUNTS IN PATIENTS WITH ADVANCED CHRONIC LIVER DISEASE

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Conflict of interest: No

Introduction and Objectives: Spontaneous portosystemic shunts (SPSSs) have been reported in 60% of cirrhotic patients and its prevalence increases with the deterioration of liver function. SPSSs are often associated with hepatic encephalopathy, gastroesophageal varices and increased risk for complications and death. Therefore, the selection of patients with a high probability of having significant SPSSs can have great impact in the management of patients with liver cirrhosis. In cirrhotic patients, liver stiffness measurements show a good correlation with the severity of disease and the occurrence of gastroesophageal varices. We hypothesize that liver stiffness values could also correlate well or even predict the presence of significant portosystemic shunts.

Patients / Materials and Methods: This was a retrospective study of 51 patients with advanced chronic liver disease/cirrhosis who underwent liver magnetic resonance imaging with elastography (MRE) from 2022 to 2023. MR images were reviewed by two radiologists looking for the presence of SPSSs, defined as spontaneous communications between the portal venous system and/or splanchnic veins and the systemic venous system. In addition, presence or absence of gastroesophageal varices was also recorded. Regarding SPSSs, patients were assigned into two groups: with and without SPSSs. Among patients with SPSSs patients were assigned into two groups: Large SPSSs (L-SPSSs, ≥8 mm), small SPSSs (S-SPSSs <8mm), or without SPSSsMedian. Levels of MRE between patients with and without SPSSs was analyzed and the accuracy of liver stiffness by MRE to predict SPSSs was evaluated by AUROC curves. A statistical significance level of 0.05 was adopted.

Results and Discussion: Among 51 included patients, 68% were male, and mean age was 64 years old. SPSSs were present in 28% of patients with only 6.5% having LSPSSs. Gastroesophageal varices were identified in 32%. Mean liver MRE stiffness values was 4.4 kPa (3.0 – 13.1 kPa). The performance of MRE for the prediction of SPSSs and gastresophageal varices was good, with an AUROC of 0.85 (0.75 – 0.97; p< 0.001) for SPSSs and 0.84 (0.72 – 0.96; p<0.001) for Gastroesophageal varices. The best MRE elastography cutoff for the presence of SPSSs and gastroesophageal varices was 5.0 kPa (S=85%,