

	N = 57
Age (years)	39 (34-51)
Sex (%)	
Women	29 (51)
Medical doctor (%)	
Gastroenterologist	46 (81)
General practitioner	11 (19)
Years of experience	7 (2-17)
Region (%)	
Coast	45 (79)
Highland	12 (21)
Medical center (%)	
Private outpatient	3 (5)
Primary health care	7 (12)
Secondary health care	23 (40)
Tertiary health care	24 (42)

General characteristics

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P-43 PROGNOSTIC MODELS AFTER TRANSARTERIAL CHEMOEMBOLIZATION IN A LATIN AMERICAN PROSPECTIVE COHORT STUDY

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Conflict of interest: No

Introduction and Objectives: With the advent of new therapeutic options for patients with hepatocellular carcinoma (HCC) at intermediate stage of the Barcelona Clinic Liver Cancer (BCLC), regional real-world data regarding prognostic survival factors are significant. The aim of this study was to evaluate pre and post-prognostic survival variables after transarterial chemoembolization (TACE).

Patients / Materials and Methods: A multicenter prospective cohort study was conducted in Argentina, Chile, Brazil, and Colombia, including HCC patients at BCLC B or C stages who were treated with TACE from 2018 to 2024. The effect on survival since date of first TACE was evaluated through Cox proportional hazard survival analysis. Harrell's c-statistic index for model discrimination was estimated through somers-d.

Results and Discussion: Overall, 625 patients were included, of which 41.3% (n=258) received TACE (Table 1), and 4.6% (n=29) selective internal radiation therapy (SIRT). The median number of TACEs procedures was 2 (range 1-3); 54.5% conventional TACE, and 44.7% with drug-eluting beads. Median follow-up since first TACE was 17.7 months, with a median overall survival of 27.3 months (range 21.9-35.1). Radiological objective response rates (ORR) after first and last TACEs were 49.2% (95% CI 42.9-55.5%), and 29.0% (95% CI 22.6-36.1%), with significantly better post TACE survival [HR of 0.48 (95% CI 0.29-0.78); P=0.003]. The pre-TACE prognostic model showed liver decompensation was an independent variable associated with increased post TACE mortality was [HR 2.0 (CI 1.28-3.12)], adjusted for performance status, and the HAP score. Pre and post-TACE model showed that the effect of liver decompensation was adjusted [HR 1.7 (CI 0.98-2.8); P=0.06], when ORR after last TACE was achieved and included in this model [HR 0.48 (CI 0.29-0.79); P=0.004], with a c-statistic index of 0.66 (95% CI 0.60-0.72).

Conclusions: Radiological response after sequential TACE might reduce the negative effect of liver decompensation on post-TACE survival. However, cautious TACE stopping rules should be considered.

Table 1. Patient and tumor characteristics immediately before transarterial chemoembolization (TACE).

VARIABLE	TACE n=258 (41.3%)
Age, years (± SD)	66 ± 9
Male gender, n (%)	192 (74.4)
Cirrhosis, n (%)	231 (89.5)
Median total Bilirubin, mg/dl (IQR)	1.1 (0.8-1.6)
Median Albumin, g/dl (IQR)	3.6 (3.1-4.0)
Median INR, (IQR)	1.2 (1.0-1.3)
Mild Ascites, n (%)	27 (10.5)
Child Pugh A/B/C, n (%)	162 (62.8)/54 (20.9)/42 (16.3)
Prior decompensation, n (%)	73 (28.3)
ECOG 0-1, n (%)	252 (97.7)
Median number of HCC nodules, (IQR)	2 (1-3)
Median target lesion diameter, mm (IQR)	45 (33-60)
Median serum AFP, ng/ml (IQR)	17.7 (5.0-147)
AFP ≥400 ng/ml, n (%)	34 (17.5)
BCLC before TACE, n (%)	
0	4 (1.5)
A	57 (22.1)
B	135 (52.3)
C	20 (7.7)
D	42 (16.3)
HAP score before TACE, n (%)	
A	54 (20.9)
B	98 (38.0)
C	76 (29.5)
D	30 (11.6)

Abbreviations: HCC: hepatocellular carcinoma. AFP: alpha-fetoprotein; IQR: interquartile range.

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