Although no association was found between the degree of steatosis and the degree of fibrosis, the patient with the highest level of fibrosis presented the highest degree of steatosis. X^2= 8.916, p=0.178

No association was found between the degree of steatosis and diabetes.

X^2= 11.723,p=0.068

However, the degree of diabetes is associated with the presence of fibrosis and the degree of fibrosis, with a weak positive correlation existing between HbA1C levels and CAP levels, Spearman's rho 0.280 p=0.015. Tables 1 and 2

Although no assessment was found between BMI and kPa to determine if there is an association between the degree of fibrosis and the nutritional level, curiously, it can be observed that a healthy patient with grade 3 fibrosis has uncontrolled diabetes. Table 3

Conclusions: Prediabetes may be a predictor of the presence of liver fibrosis associated with MASLD.

Table 1 Association between the degree of diabetes and the presence of fibrosis

Fibrosis /Diabetes degree	Healthy n (%)	Prediabetes n (%)	Controlled Diabetes n (%)	Uncontrolled Diabetes n (%)
Healthy	32 (49.2)	25 (38.5)	7 (10.8)	1 (1.5)
Fibrosis	3 (30)	2 (20)	4 (40)	1 (10)
X^2= 8.883, p=0.031				

Table 2 Association between the degree of diabetes and the presence of fibrosis

Fibrosis /Diabetes degree	Healthy n (%)	Prediabetes n (%)	Controlled Diabetes n (%)	Uncontrolled Diabetes n (%)
F0-F1	32 (49.2)	25 (38.5)	7 (10.8)	1 (1.5)
F2	1 (16.7)	2 (33.3)	3 (50)	0 (0)
F3	2 (66.7)	0 (0)	0 (0)	1 (33.3)
F4	0 (0)	0 (0)	1 (100)	0 (0)
X^2= 25.796, p=0.002				

Table 3 Association between the degree of fibrosis and nutritional status

Degree of fibrosis/ Nutritional status	Healthy n (%)	Overweight n (%)	Obesity I n (%)	Obesity II n (%)	Obesity III n (%)
F0-F1	3 (4.6)	22 (33.8)	35 (53.8)	4 (6.2)	1 (1.5)
F2	0 (0)	2 (33.3)	1 (16.7)	3 (50)	0 (0)
F3	1 (33.3)	2 (66.7)	0 (0)	0 (0)	0 (0)
F4	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)
X^2= 21.524 p=0.043					

https://doi.org/10.1016/j.aohep.2024.101688

P-75 INFLUENCE OF THE ARTERIAL HEPATIC FLOW IN ELASTOGRAPHY (2D SHEARWAVE) LIVER VALUES

Diego Arufe[1], Nancy Cordero[1], Edgar Suarez[1], Ezequiel Demirdjian[1]

[1] *SANATORIO SAGRADO CORAZON, Buenos Aires, Argentina*

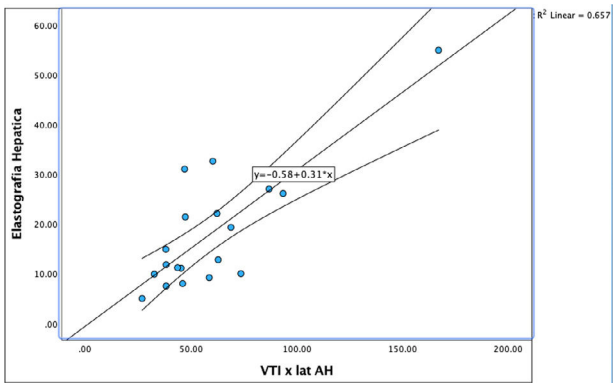
Conflict of interest: No

Introduction and Objectives: The liver receives blood at low pressure through the portal vein (80%). Distortion of hepatic histoarchitecture, reduces portal flow and increases hepatic arterial flow (HAF). Liver elastography (LE) non-invasively measures liver stiffness (LS), but intrahepatic and extrahepatic factors also influence LS. The velocity-time integral of the hepatic artery (HAVTI) estimates the area under the spectral Doppler curve. This study investigates the correlation between LS and HAVTI in cirrhosis patients, aiming to explain dynamic LS changes in cirrhosis and portal hypertension.

Patients / Materials and Methods: Elastography and spleno-portal Doppler were performed on cirrhosis patients under follow-up at Sanatorio Sagrado Corazón. The median of five LS measurements was determined, and the HAVTI was measured in the same study. Spearman's correlation method was used to establish the correlation between LE values and HAVTI

Results and Discussion: Twenty cirrhosis patients were evaluated (65% men), with a median age of 58 years. The most common etiology was HCV (35%), followed by alcohol use disorders (30%). Seventy percent were CHILD A (median MELD-Na 10). At the time of the study, 68.4% had experienced at least one decompensation event. We found a correlation of r = 0.65 (p = 0.004) between hepatic elastography values and HAVTI.

Conclusions: Our study demonstrates a significant correlation between LS and HAVTI in cirrhosis patients. This suggests that non-invasive HAVTI assessment may provide valuable insights into dynamic LS changes associated with cirrhosis and portal hypertension.



Correlación Elastografia hepatica / VTI art Hepatica

https://doi.org/10.1016/j.aohep.2024.101689

P-76 MANIFESTATIONS OF PORTAL HYPERTENSION IN PATIENTS WITH COMMON VARIABLE IMMUNODEFICIENCY: PRELIMINARY DATA

VERONICA GUIDO[1], Belen Russo[2], Daniela Chiodi[3], Nelia Hernandez[3]

[1] *HOSPITAL DE CLINICAS, Montevideo, Uruguay*
[2] *Hospital de Clínicas, Montevideo, Uruguay*
[3] *Hospital de Clinicas, Montevideo, Uruguay*

Conflict of interest: No

Introduction and Objectives: Liver involvement in common variable immunodeficiency (CVID) can be found in 9% to 79% of cases and may lead to reduced survival. Anicteric cholestasis and portal hypertension (PH) were the main hepatic manifestations. We aimed to establish the prevalence and characteristics of PH in patients with

CVID under treatment at a primary immunodeficiency clinic of a tertiary-level hospital.

Patients / Materials and Methods: A retrospective and descriptive study examined the medical records of patients with confirmed CVID.

Results and Discussion: out of the eleven patients with CVID, eight were women, and the median age was 34 years (range 23-72). PH was suspected in five (45.4%), with three patients experiencing clinically significant PH and one case complicated by variceal bleeding. Table 1 compares both groups (with and without PH). Thrombocytopenia was found in most patients, consistent with the higher incidence of splenomegaly. Liver biopsies performed only in two patients with suspected PH excluded cirrhosis but identified regenerative nodular hyperplasia in one case. Both cases had liver stiffness measurements by shear wave elastography, showing a median of 14.2 kPa. No association was identified with other non-infectious complications of CVID (gastrointestinal and pulmonary disease).

Conclusions: Liver disease is often underdiagnosed in patients with CVID, with portal hypertension appearing to be frequent. Early screening is essential to avoid severe complications.

	With portal hypertension (n=5)	Without portal hypertension (n=6)
Years from CVID diagnosis	11,4 (7-14)	7,6 (4-17)
Female	4	4
Age at PH diagnosis	45,6 (22-70)	-
Pulmonary disease	4	4
Gastrointestinal disease	1	1
Cholestasis	2	0
Splenomegaly	4	0
Thrombocytopenia	4	0
Gastro-esophageal varices/Upper bleeding	2 (3 no data)/1	0
Ascites	1	0

Table: comparison between patients with and without evidence of portal hypertension.

https://doi.org/10.1016/j.aohep.2024.101690

P-77 TRIPLE THERAPY FOR DIFFICULT-TO-TREAT PRIMARY BILIARY CHOLANGITIS: A SYSTEMATIC REVIEW AND SINGLE-ARM META-ANALYSIS

Eliabe Silva de Abreu[1],
Deivyd Vieira Silva Cavalcante[2],
Jaqueline Cardoso Habib[3],
Jorge Ferreira Jasmineiro Pitanga[4],
Ana Clara Felix de Farias Santos[5],
Guilherme Grossi Lopes Cançado[3]

[1] *Mayo Clinic, Rochester, Estados Unidos (EEUU)*
[2] *Universidade Ceuma, São Luís, Brasil*
[3] *Universidade Federal de Minas Gerais, Belo Horizonte, Brasil*
[4] *Universidad de Buenos Aires, Buenos Aires, Argentina*
[5] *Universidade Cidade de São Paulo, São Paulo, Brasil*

Conflict of interest: No

Introduction and Objectives: High-risk patients with primary biliary cholangitis (PBC) who respond incompletely to ursodeoxycholic acid (UDCA) require additional treatment with fibrates or obeticholic acid (OCA). Despite this, 30-50% of these patients continue to exhibit elevated alkaline phosphatase (ALP) and bilirubin levels, classifying them as difficult-to-treat PBC. This study aims to evaluate the effects of triple therapy (UDCA + OCA + fibrates) on liver biochemistry in patients with difficult-to-treat PBC.

Patients / Materials and Methods: We systematically reviewed EMBASE, PubMed, and Cochrane databases to identify eligible studies. Pooled analyses were performed for change-from-baseline data. We also conducted subgroup analyses based on the sequencing of the specific add-on drug used as third-line therapy. Statistical analyses were performed using RStudio (2023.12.1+402).

Results and Discussion: Two studies provided change-from-baseline data, encompassing 95 patients under triple therapy, of whom 68.4% (n=65) had fibrates added to UDCA+OCA dual therapy. Overall, patients under triple therapy presented with decreased ALP [-0.82 x upper limit of normal (ULN), 95%CI -0.96 to -0.68], bilirubin (-0.06 x ULN; 95%CI -0.11 to -0.01), and GGT (-3.18 x ULN; 95%CI -4.57 to -1.79) levels compared to the last available result on dual therapy. No significant change was noted for AST (-0.08 x ULN; 95%CI -0.44 to 0.28) and ALT (-0.21 x ULN; 95%CI -0.61 to 0.20) concentrations. However, the addition of OCA to UDCA+fibrates dual therapy significantly reduced AST (-0.53 x ULN; 95%CI -0.73 to -0.33; p-value for subgroup differences < 0.001) and ALT (-0.69 x ULN; -0.97 to -0.40; p<0.001) levels. On the other hand, adding fibrates to the UDCA+OCA scheme was superior in reducing ALP levels (p=0.049).

Conclusions: Triple therapy appears to reduce liver enzyme levels in patients with difficult-to-treat PBC. Further studies are warranted to clarify the optimal sequencing and to identify the subgroups that benefit the most from this combination therapy.

https://doi.org/10.1016/j.aohep.2024.101691

P-78 DECOMPENSATED CIRRHOSIS IN A LARGE MULTINATIONAL COHORT IN LATIN AMERICA: MORTALITY IS TOO HIGH IN THE REGION REGARDLESS OF ETIOLOGY AND COUNTRY

Mario Alvares-Da-Silva Reis[1], Aldo Torre[2],
Carlos Benitez[3], Jacqueline Cordova-Gallardo[4],
Alberto Farias Queiroz[5], Sarai Gonzalez-Hueso[6],
Rene Male Velazquez[7], Sebastian Marciano[8],
Gustavo Pereira[9], Jose Luis Perez-Hernandez[10],
Jose Antonio Velarde-Ruiz[11], Marco Arrese[3],
Araceli Bravo Cabrera[6], Francisco Felix-Tellez[11],
Adrian Gadano[12], Oscar Morales Gutierrez[10],
Matheus Michalczuk[13], Lilian Torres[7], Scott Silvey[14],
Brian Bush[14], Jasmohan Bajaj S[15]

[1] *UNIVERSIDADE FEDERAL DO RIO GRANDE DO SUL, PO, Porto Alegre, Brasil*
[2] *Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Mexico City, Mexico*
[3] *Pontificia Catholic University of Chile, Santiago, Chile*
[4] *Hepatology, Hospital General Dr. Manuel Gea Gonzalez, Mexico City, Mexico City*
[5] *Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo, São Paulo*
[6] *Centro Médico ISSEMYM, Mexico City, México*
[7] *Instituto de la Salud Digestiva, Guadalajara, Guadalajara, México*
[8] *Hospital Italiano de Buenos Aires, Argentina, Buenos Aires, Argentina*
[9] *Hospital Federal de Bonsucesso, Rio de Janeiro, Brasil*
[10] *Hospital General de México "Dr. Eduardo Liceaga", Mexico City, México*
[11] *Hospital Civil de Guadalajara Fray Antonio Alcalde, Guadalajara, México*
[12] *Hospital Italiano, Buenos Aires, Argentina*