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.

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

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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.

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

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Conflict of interest: No

Introduction and Objectives: Decompensated cirrhosis (DC) is an important cause of death worldwide, including in Latin America. This study aimed to evaluate in-hospital and 30-day post-discharge mortality in a multinational cohort in Latin America.

Patients / Materials and Methods: Non-elective cirrhosis admissions from Nov 2021 to Aug 2022 in sites from Mexico, Brazil, Argentina and Chile were included. Demographics, admission medications, prior conditions, etiology, and other data around admission were collected from patients and their medical records. Continuous variables were summarized using mean (± SD), and categorical variables as counts (%). Main outcomes were inpatient mortality/hospice and 30-day post-discharge mortality. Univariable comparisons were compared between outcomes using two-sample *t*-tests or chi-squared tests as appropriate. Multivariable models controlling for all variables significantly associated with outcomes at the $p < 0.05$ level were fit.

Results and Discussion: Of 651 patients with valid inpatient outcomes, 158 died in-hospital or were moved to hospice (24.3%). At 30-days, 139 were lost to follow-up, leaving 512 patients. Of these, 172 died by 30 days (33.6%). In-hospital and 30-days mortality were not affected by etiology (HBV, HCV, MASLD, crypto). Variables significantly associated with mortality at both timepoints were prior LVP/HE, admission medications, prior infection, liver-related admission, and higher MELD-Na (Table 1). On multivariable analysis, admission betablockers and lactulose were associated with high mortality; MELD-Na and infection on admission were associated to death at both timepoints (Table 2)

Conclusions: DC is associated with significant in-patient and 30-day mortality in the region, regardless of etiology and country, especially in patients with higher MELD-Na and/or infected on admission.

Table 1.

Variable	Inpatient Outcomes (n = 651)			30-Day Outcomes* (n = 512)		
	Survived/LT (n = 493, 75.7%)	Death/ Hospice (n = 158, 24.3%)	*p*-value	Survived/LT (n = 340, 66.4%)	Death (n = 172, 33.6%)	*p*-value
Age (years)	57.96 (±13.11)	56.59 (±12.73)	0.24	56.50 (±12.93)	56.34 (±12.82)	0.89
Male Sex	273 (55.4%)	88 (55.7%)	>0.99	200 (58.9%)	97 (56.4%)	0.67
Cirrhosis Etiology						
Hepatitis C	81 (16.4%)	20 (12.7%)	0.31	55 (16.2%)	22 (12.8%)	0.38
NAFLD/MASLD	123 (24.9%)	36 (22.8%)	0.66	72 (21.2%)	37 (21.5%)	>0.99
Hepatitis B	5 (1.0%)	2 (1.3%)	>0.99	4 (1.2%)	2 (1.2%)	>0.99
Cryptogenic	46 (9.3%)	18 (11.4%)	0.55	33 (9.7%)	19 (11.0%)	0.75
Others	12 (2.4%)	1 (<1.0%)	0.28	8 (2.4%)	2 (1.2%)	0.56
Prior AKI	79 (16.0%)	27 (17.1%)	0.85	60 (17.6%)	35 (20.3%)	0.53
Prior Hydrothorax	24 (4.9%)	15 (9.5%)	0.05	18 (5.3%)	17 (9.9%)	0.08
Cirrhosis History						
Prior LVP (6mo)	36 (7.3%)	29 (18.4%)	<0.001	32 (9.4%)	24 (14.0%)	0.16
Hospitalized (6mo)	174 (35.3%)	62 (39.2%)	0.42	130 (38.2%)	71 (41.3%)	0.57
Prior HE (6mo)	180 (36.5%)	77 (48.7%)	0.008	123 (36.2%)	89 (51.7%)	0.001
Variceal Bleed (6mo)	189 (38.3%)	55 (34.8%)	0.48	120 (35.3%)	62 (36.0%)	0.94
Transplant Listed?	75 (15.2%)	37 (23.4%)	0.02	69 (20.3%)	30 (17.4%)	0.51
Infected in Past 6mo	78 (15.8%)	32 (20.3%)	0.24	63 (18.5%)	36 (20.9%)	0.60
Prior HCC (6mo)	36 (7.3%)	16 (10.1%)	0.33	25 (7.4%)	18 (10.5%)	0.30
Admission Details						
Beta-Blocker	237 (48.1%)	51 (32.3%)	<0.001	150 (44.1%)	63 (36.6%)	0.13
Lactulose	180 (36.5%)	89 (56.3%)	<0.001	119 (35.0%)	93 (54.1%)	<0.001
Rifaximin	97 (19.7%)	44 (27.8%)	0.04	68 (20.0%)	52 (30.2%)	0.01
Diuretics	225 (45.6%)	83 (52.5%)	0.16	152 (44.7%)	92 (53.5%)	0.07
PPI	167 (33.9%)	56 (35.4%)	0.79	104 (30.6%)	58 (33.7%)	0.54
Statins	57 (11.6%)	14 (8.9%)	0.42	29 (8.5%)	17 (9.9%)	0.73
SBP Prophylaxis	68 (13.8%)	29 (18.4%)	0.20	46 (13.5%)	30 (17.4%)	0.30
HBV antivirals	7 (1.4%)	2 (1.3%)	>0.99	2 (<1.0%)	3 (1.7%)	0.44
Infection Admission	122 (24.7%)	68 (43.0%)	<0.001	80 (23.5%)	81 (47.1%)	<0.001
Liver Related Admission	439 (89.0%)	154 (97.5%)	0.002	306 (90.0%)	166 (96.5%)	0.02
MELD-Na	19.76 (±7.69)	26.76 (±6.86)	<0.001	20.29 (±7.65)	27.22 (±7.27)	<0.001

Table 2.

Variable	Inpatient Death/Hospice		30-Day Death	
	OR (95% CI)	*p*-value	OR (95% CI)	*p*-value
Admission Beta-Blocker	0.54 [0.34-0.85]	0.003	–	–
Admission Lactulose	3.08 [1.68-5.72]	<0.001	1.54 [0.88-2.69]	0.13
Infection on Admission	1.81 [1.16-2.82]	0.009	2.32 [1.59-3.62]	<0.001
MELD-Na	1.12 [1.08-1.15]	<0.001	1.11 [1.08-1.15]	<0.001

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P-79 CHARACTERISTICS AND OUTCOMES OF TRANSJUGULAR INTRAHEPATIC PORTOSYSTEMIC SHUNT (TIPS) RECIPIENTS IN A TERTIARY HOSPITAL. LIMA - PERU (JANUARY 2019 - MARCH 2024)

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Conflict of interest: No

Introduction and Objectives: Portal Hypertension (PHT) is the determining event of decompensations in liver cirrhosis, increasing its mortality. TIPS is an effective strategy for the management of PHT; however, in Latin America there are few studies on this topic. *Objective:* To describe characteristics and results of TIPS recipients in a tertiary hospital in Lima (Peru) from January 2019 to March 2024.

Patients / Materials and Methods: This observational, retrospective and cross-sectional study reviewed all medical records of patients ≥ 18 years old undergoing TIPS between January 2019 and March 2024, performed by Interventional Radiology Service. For statistical analysis, SPSS 29 software was used.