P-81 LIVER TRANSPLANTATION FOR PRIMARY BILIARY CHOLANGITIS (PBC): 25-YEAR EXPERIENCE.

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Conflict of interest: No

Introduction and Objectives: Ten-year survival after liver transplantation (LT) in PBC is around 80%; disease recurrence (DR) occurs in 17-46%, with patient and graft survival impact. OBJECTIVES: To evaluate the epidemiological profile of patients transplanted due to PBC and recurrence risk factors.

Patients / Materials and Methods: Retrospective cohort analysis from 1997 to 2022. Until 2002, standard immunosuppression (IS) was with cyclosporine (CYA); later tacrolimus (TAC). From 2019, preemptive ursodeoxycholic acid (UDCA) was started in the first 3 months of LT to prevent DR (46.2%).

Results and Discussion: 28 patients were evaluated, 96.4% female with 52.4±9.7years at LT (2 living donor). The pre-LT data are shown in Table 1. Five patients were transplanted due to exception points (3 pruritus, 1 refractory ascites, 1 encephalopathy). After LT, 11 presented acute cellular rejection (ACR) (2 cases during the switch of TAC to CYA to prevent DR) and 4 CMV infection (14.3%). The DR rate was 46.4% in 6.34±5.5 years post-LT, most of them stage I. At relapse, 53.9% were using CYA. Four patients (14.3%) died. The preemptive use of UDCA was associated with a lower risk of recurrence (25 × 71.4%, p=0.047). There was no impact of recurrence on patient survival.

Conclusions: In literature CYA is associated with a lower risk of DR and greater survival, however, in our cohort, > 50% were using the medication at relapse. Some cases of ACR occurred at the shift of TAC to CYA. It's important to discuss the ideal time to IS conversion, particularly during the first 6 months and to use preemptive UDCA to reduce DR. Although almost 50% of patients relapsed, deaths were not related to recurrence. The preemptive use of UDCA post-LT appears to be associated with lower DR, with no impact on survival, probably due to the short follow-up period.

Table 1: Pre-LT data

Gender n(%)	
Male	1 (3.57 %)
Female	27 (96.42%)
Age (mean ± SD) (years)	
At diagnosis of PBC	46.6±10
At Liver transplant	52,45±9.7
Pré LT complications n (%)	
Ascites	9 (35.7)
Upper Gastrointestinal Bleeding	7 (25)
Encephalopathy	4 (14.3)
Spontaneous bacterial peritonitis	2 (7.1)
LT indications n (%)	
Loss of function	23 (82.1%)
Exception points	5 (17,8%)
Donor age (mean ± SD) (years)	39.42±15
Donor/recipient sex disparity n (%)	11 (39.6 %)

Table 2: Post-LT data

Preemptive UDCA n (%)	12 (46.2)
Acute cellular rejection n (%)	11 (39.3)
Exchange of TAC for CYA	2 (7.1)
Cytomegalovirus	4 (14.3)
PBC recurrence n (%)	13 (46.4)
Use of CYA	7/13 (5.9)
Deaths n (%)	4 (14.3)
Early complications	2 (7.14)
HBV de novo	1 (3.5)
Pancreatic neoplasm	1 (3.5)
10-year survival	85%

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P-82 IMPACT OF HEPATITIS C VIRUS ERADICATION WITH DIRECT ANTIVIRAL DRUGS ON GLYCEMIC CONTROL AFTER LIVER TRANSPLANTATION

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Conflict of interest: No

Introduction and Objectives: Liver transplant patients have increased risk of type 2 diabetes (T2DM). Although hepatitis C virus (HCV) is an independent risk factor for insulin resistance and T2DM, there is no consensus on the impact of antiviral treatment on sustained glycemic control, particularly in liver transplant patients with HCV (HCV-LT). *Objective:* Evaluate the impact of viral HCV eradication with direct antiviral drugs on long term glycemic control of HCV-liver transplanted (HCV-LT) patients.

Patients / Materials and Methods: A retrospective cohort of HCV-LT recipients with sustained virological response (SVR) after direct-antiviral treatment (DAA) was included in this longitudinal study. Clinical and laboratory data were collected before antiviral treatment and sequentially after SVR. A Cox Regression analysis was performed to evaluate the variables associated with glycated hemoglobin (A1C) on target (≤ 7% and ≤ 5.6% with and without T2DM) at the end of the follow-up period.

Results and Discussion: Overall, 140 eligible HCV-LT patients were included (64% male, 63 ± 9 yrs, 15% with BMI ≥ 30 kg/m2, 64% with T2DM) and followed for 43 (19-70) months. After LT, 79% used tacrolimus, 34% Sirolimus and 14% prednisone. Before treatment 71% had A1C on target. At follow up this rate increased to 77%, with add-on insulin/increased doses in 14%, withdraw/reduced doses in 12% and diet/oral treatment in 76% of HCV-LT patients.

On multivariate Cox analysis, A1C on target at follow-up were independently associated with diet/oral treatment (HR:2.77; 95%CI,1.33-5.78;p=0.006) and time between LT and end of DAA treatment (HR:0.996; 95%CI,0.992-1.000;p=0.045), adjusted for age, gender, weight gain and immunosuppressants.

Conclusions: Over 70% of HCV-LT patients with SVR remained in good glycemic control over time, which was associated with initial and long-lasting non-insulin treatment. Of note, A1C on target was