

P-102 PERFORMANCE OF NONINVASIVE METHODS TO GRADUATE FIBROSIS AND INFLAMMATION IN A GROUP OF PATIENTS WITH AUTOIMMUNE HEPATITIS

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Conflict of interest: No
Introduction and Objectives: Liver biopsy is considered the gold standard to define fibrosis stage and inflammation degree in Autoimmune Hepatitis (AIH). Noninvasive methods have been utilized for these purposes. However, the respective accuracies in different populations have not been clarified. **AIMS:** Investigate the performance of TE and APRI and of serum IgG and γ -glob levels in defining liver fibrosis and inflammation degree, respectively, in a group of patients with AIH.
Patients / Materials and Methods: Prospective study involving patients with AIH who underwent liver biopsy (classified by Metavir and Ishak) and TE (FibroScan, Echosens 502), with a maximum interval of 6 months between the two procedures. Laboratory parameters for APRI, IgG and γ -glob were obtained within a maximum interval of 3 months from the biopsy. The performances were compared with liver biopsies using ROC curves.
Results and Discussion: 63 patients with AIH were included (88% female; mean age 43 ± 18 years), platelets levels: $214.524 \pm 72.121/\mu\text{L}$. Medians: IgG:1530, APRI: 0.4 and TE: 8.8 kPa. Liver fragments had ≥ 8 complete portal spaces. Thirty-four patients (54%) had advanced fibrosis ($F \geq 3$ METAVIR) and 67% had inflammation $A \leq 1$ by METAVIR and $A < 6$ by ISHAK. Correlations of IgG and γ -glob with inflammation were poor ($R=0.21$; $P=0.20$ and $R=0.29$; $P=0.09$, respectively). Regarding fibrosis, the best correlation was with TE ($R=0.61$; $P<0.001$), AUROC value of 0.84 (95% IC:0.73-0.92; $P<0.0001$) and moderate correlation was observed with APRI ($R=0.44$; $P<0.001$), AUROC value of 0.78 (95% IC: 0.66-0.88; $P<0.001$). The best cutoff of TE to define advanced fibrosis was 7.9 kPa (sensitivity:84%; specificity=74%). Regarding APRI, the best cutoff for advanced fibrosis was 0.24 (sensitivity: 97%; specificity=50%).
Conclusions: Compared to APRI, TE showed the best performance in defining advanced fibrosis, with good accuracy. APRI had a moderate correlation with fibrosis. None IgG nor γ -glob showed good correlations with inflammation. Further studies are needed to confirm these findings.

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P-103 AN ELEVATED BASELINE LEVEL OF ALKALINE PHOSPHATASE, ALANINE AMINOTRANSFERASE, AND ASPARTATE AMINOTRANSFERASE PREDICT A LACK OF BIOCHEMICAL RESPONSE TO UDCA THERAPY AMONG HISPANIC PATIENTS LIVING WITH PRIMARY BILIARY CHOLANGITIS

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Conflict of interest: No
Introduction and Objectives: Primary biliary cholangitis (PBC) is a chronic, progressive, autoimmune liver disease characterized by the destruction of the small bile ducts within the liver. Ursodeoxycholic acid (UDCA) is the first-line treatment for PBC, shown to improve liver biochemistry and delay disease progression. However, the response to UDCA therapy is variable among patients, with some failing to achieve a satisfactory biochemical response. Identifying predictors of non-response is crucial for optimizing treatment strategies and improving patient outcomes. Recent evidence has shown a lower biochemical response among patients of Hispanic ethnicity, which is often underrepresented in clinical research. The findings have significant implications for clinical practice, and are of particular interest in countries that have limited access to liver transplantation.
Patients / Materials and Methods: This is a single center, retrospective, propensity score-matched cohort study, which included all patients with PBC confirmed by liver biopsy that were followed by the hepatology clinic from January 1st, 2015 to March 1st 2024 under treatment with UDCA. A biochemical response was defined according to the Toronto criteria, with an alkaline phosphatase (ALP) $<1.67 \times \text{ULN}$ after 2 years of UDCA therapy. Patients were subdivided on the presence or absence of a biochemical response. The primary outcome was mortality due to a liver related event (LRE), the secondary outcomes were variables associated with non-response.
Results and Discussion: A total of 132 patients were included, 70 were non responders and 62 fulfilled Toronto criteria of response. The predominant gender was female in both groups (96.78% and 96%) with a median of 56 years of age for the non-responders and 58 years for those who did. Mortality due to LRE in the no response vs responders group was 41% vs 6.2%, respectively, a difference which was statistically significant (OR 3.67, 95% CI [1.608, 8.411], $p<0.001$). Factors associated with incomplete response were statistically significant for a baseline level of ALP $> 2 \times \text{ULN}$ (OR 5.3, 95% CI [2.433, 11.649], $p<0.001$), a baseline level of ALT $> \text{ULN}$ (OR 5.3, 95% CI [2.429, 11.845], $p<0.001$) and a baseline level of AST $> \text{ULN}$ (OR 7.8, 95% CI [3.554, 17.159] $p<0.001$). All of these variables remained ss after multivariate regression analysis.
Conclusions: Among patients with PBC that receive initial therapy with UDCA, a baseline increased ALP, AST and ALT are associated with an incomplete biochemical response, identifying patients that might benefit from early initiation of additional therapies. Prospective studies are needed.

Variables	Toronto criteria(n=62)	No response(n= 70)
Age mean(years)	58	56
Gender= Female –no. (%)	96.7 %	96 %
T2D	12%	14%
HBP	8%	6%
Previous diuretic therapy	11%	9%
Cirrhosis	63%	60%
CTP mean	A (6)	A (6)
Liver related events	27%	35%

Table 1. Baseline patient characteristics.

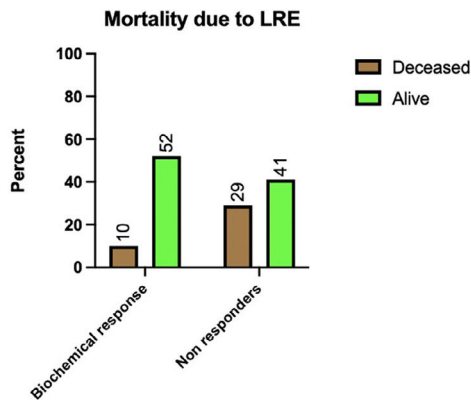


Figure 1: Mortality for LRE
Mortality due to LRE, among patients who fulfilled Toronto criteria for Biochemical response vs those who did not. OR 3.67, 95% CI [1.608 , 8.411], p<0.001

Multivariate regression *	OR (95% CI)	p value
ALP > 2x ULN	3.13 (3.02-3.15)	0.0476
ALT > ULN	2.82 (2.78-2.86)	0.0465
AST > ULN	3.06 (3.01-3.11)	0.0483

Table 2. Multivariate regression analysis of variables associated with no response.
*Adjusted for sex, age, autoimmune diseases. Only overall mortality and development of respiratory failure remained statistically significant.

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P-104 PREVALENCE AND SEVERITY OF MASLD AND ITS ASSOCIATION WITH METABOLIC COMORBIDITIES: INSIGHTS FROM A LINKAGE TO CARE PROGRAM FOR FATTY LIVER DISEASE

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Conflict of interest: No
Introduction and Objectives: Metabolic-associated steatotic liver disease (MASLD) is prevalent and linked to comorbidities such as obesity, diabetes, and hypertension. This study aimed to conduct a fatty liver detection campaign as part of a linkage to care program for MASLD at Hospital El Cruce in Buenos Aires and to evaluate its association with metabolic comorbidities.
Patients / Materials and Methods: The community was invited to participate in liver evaluations through a background survey and transient elastography (FibroScan® 530). Adults over 18 years old without known chronic liver diseases, excluding MASLD, were included. Patients were classified by CAP into steatosis positive or negative, and significant fibrosis defined as >7 kPa and advanced fibrosis as >15 kPa. Data on BMI, diabetes, hypertension, and dyslipidemia were collected. Patients with significant alcohol consumption were excluded and followed up. Statistical analyses included Student's t-test, chi-square test, and Fisher's exact test.

Results and Discussion: From March 6 to July 5, 2024, 321 evaluations were conducted. Of these, 62.1% were women and 37.9% men (p=0.07). The mean age was 56 ± 11.3 years, 58.4 ± 10.9 years for women, and 54 ± 11.6 years for men. Moderate to severe steatosis was observed in 85.2% (273/321) of patients. Additionally, 22.1% (71/321) had significant fibrosis and 6.5% (24/321) had advanced fibrosis. The median BMI was 34.6, with 82.1% presenting obesity, 13.7% overweight, and 4.2% normal. Comorbidities included diabetes (47.4%), hypertension (42.1%), and dyslipidemia (30.5%). The combination of obesity and diabetes was more common in patients with advanced fibrosis compared to those with significant fibrosis (62.5% vs. 32.4%, p=0.051).

Conclusions: This study highlights the high prevalence of significant and advanced fibrosis in MASLD patients, by. The strong association between obesity, diabetes, and advanced fibrosis underscores the need for early detection and targeted interventions in high-risk populations. Managing these comorbidities is crucial for improving outcomes in MASLD patients.

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P-105 RISK FACTORS FOR MORTALITY IN PATIENTS WITH DECOMPENSATED CIRRHOSIS DURING HOSPITALIZATION

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Conflict of interest: No
Introduction and Objectives: Cirrhosis is a highly prevalent disease, classified into compensated, decompensated, and advanced stages. The risk of death is higher in patients with decompensated and advanced cirrhosis. Various risk factors are associated with mortality. **Objective:** To determine the main risk factors for mortality in patients with decompensated cirrhosis in the gastroenterology service of the General Hospital "Dr. Eduardo Liceaga".
Patients / Materials and Methods: This is an observational, longitudinal, prospective, and analytical study in a cohort of patients with cirrhosis of various etiologies, with and without acute kidney injury (AKI), who were hospitalized during 2022 and followed up to the present date (2024). Patients who were lost to follow-up or diagnosed with hepatocellular carcinoma were excluded. Data was analyzed using SPSS version 23. Qualitative variables were reported as frequencies and percentages, while numerical variables were presented as means and standard deviations or medians and ranges, depending on their distribution. Multivariable analysis was performed using logistic regression to calculate adjusted odds ratios (OR) for each predictive factor. A p-value < 0.05 was considered statistically significant
Results and Discussion: A total of 110 patients with cirrhosis were included, 54 men (49%) with a mean age of 54 ± 8 years, and 56 women (51%) with a mean age of 56 ± 9.7 years. The most frequent etiology of cirrhosis was MASLD (41%), followed by alcohol (39%), with 10 patients having alcohol-induced hepatitis (9%). The Child-Pugh classification distribution was: A: 12 patients (11%), B: 40 patients (36%), and C: 58 patients (53%). Additionally, 37 patients presented ACLF (34%). During follow-up, 28 patients died during