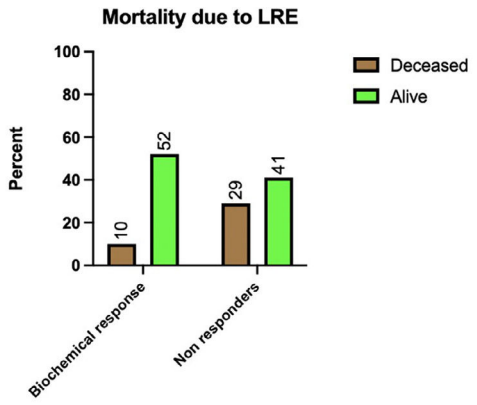

Figure 1: *Mortality for LRE*
Mortality due to **LRE,** among patients who fulfilled Toronto criteria for Biochemical response vs those who did not. OR 3.67, 95% CI [1.608 , 8.411], p<0.001

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

hospitalization and 49 within 24 months, with an overall mortality rate of 44.5%. Among the patients, 56 (45%) developed AKI, of which 44 (36%) had a prior episode. Additionally, 25 patients (20%) had an infection at admission or during hospitalization, and 28 (22%) experienced shock. The results showed that AKI and shock during hospitalization were the most significant factors. Shock during hospitalization had an OR of 3.886 (95% CI: [1.928, 7.835]), $p < 0.001$, and AKI an OR of 3.540 (95% CI: [1.767, 7.092]), $p < 0.001$, with a significant model according to the Chi-square test ($x2 = 46.6$, $p < 0.0001$). (Figure 1)

Conclusions: AKI and shock during hospitalization are significant predictive factors of mortality at two years. Early recognition and management of these factors are crucial to improve patient outcomes.

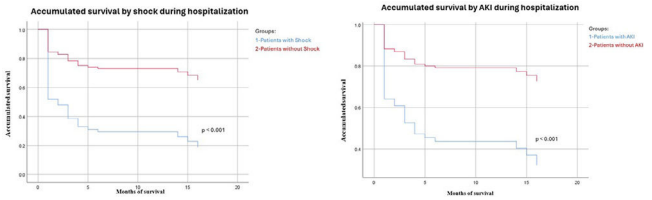

Figure 1

https://doi.org/10.1016/j.aohep.2024.101719

P-106 DIAGNOSTIC ACCURACY OF SHEAR-WAVE ELASTOGRAPHY IN METABOLIC DYSFUNCTION –ASSOCIATED STEATOTIC LIVER DISEASE, A SINGLE CENTER REPORT

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Conflict of interest: No

Introduction and Objectives: Metabolic dysfunction-associated steatotic liver disease (MASLD), the most prevalent liver disease in history, requires non-invasive tests to assess fibrosis and determine follow-up. The limited access and high cost of FibroScan necessitate the validation of other alternatives. The objective of this study is to assess the diagnostic accuracy of short-wave elastography (SWE).

Patients / Materials and Methods: This single-center, retrospective study was conducted from 2022 to 2024. We identified patients who underwent SWE as a non-invasive test to assess liver fibrosis. Clinical and demographic characteristics were ascertained by reviewing medical records. Clinical evidence of advanced fibrosis was defined by the presence of clinically significant portal hypertension (CSPH).

SWE (Philips Affiniti 70G Ultrasound with ElastQ imaging software, Koninklijke Philips N.V., Amsterdam, Netherlands) was performed after a 6-hour fast, with patients in a slight left lateral decubitus position. At least 10 measurements were taken for each patient. Mean and median rigidity were measured in kilopascals (KPa), with >13 KPa defined as the cut-off to rule in compensated advanced chronic liver disease (cACLD) and <9 Kpa to rule out significant fibrosis.

Sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) were calculated for the cut-off score.

Results and Discussion: A total of 86 patients were identified, with a mean age of 55 (range 22-79), 68.8% females, and 47.8% with MASLD as the predominant etiology of chronic liver disease. Overall, 31.4% were previously known to have CSPH. Within the MASLD subgroup, the FIB-4 score had a 100% PPV (under 1.31) compared to 80% with SWE to rule out fibrosis but with a higher sensitivity compared to FIB-4 (53.3% vs 35.7%). Regarding ruling in advanced fibrosis, SWE had a sensitivity of 92.9% vs 88.9% in FIB-4 with a NPV of 80%. See Table 1.

Conclusions: SWE has an excellent NPV to rule out advanced fibrosis and higher sensitivity than FIB-4 to rule out fibrosis. Recent guidelines recommend using at least two non-invasive tests to assess fibrosis. While the study is limited by its power and retrospective nature, the results show that SWE can be used as a first or second test when assessing fibrosis. Further studies with larger populations are needed to establish it as a viable option.

Table 1

	RULE-OUT FIBROSIS		ADVANCED FIBROSIS / ACLD	
	FIB-4	SWE	Fib-4	SWE
SENSITIVITY, % (95% CI)	35.7 (21.4-50)	53.3 (38.4-68.2)	88.9 (79.5-98.3)	92.9 (85-100)
SPECIFICITY, % (95% CI)	100	92.9 (85.2-100)	43.7 (28.9-58.6)	53.3 (38.4-68.2)
POSITIVE PREDICTIVE VALUE, % (95% CI)	100	80 (68-92)	72.7 (59.4-86)	78.8 (66.6-91)
NEGATIVE PREDICTIVE VALUE, % (95% CI)	45.4 (30.1-60.3)	78.8 (66.6-91)	70 (56.3-83.7)	80 (68-92)

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P-107 CLINICAL SPECTRUM OF METABOLIC DYSFUNCTION–ASSOCIATED STEATOTIC LIVER DISEASE (MASLD) IN PATIENTS WITH ALTERED ANKLE-BRACHIAL INDEX (ABI) AND CARDIOVASCULAR (CV) RISK FACTORS.

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Conflict of interest: No

Introduction and Objectives: MASLD is the most common chronic liver disease (CLD) with a worldwide prevalence of 25%. It is defined as >5% steatosis without any other known liver disease. Cardiovascular disease (CVD) is the most common cause of death in MASLD. Due to its association with atherosclerosis and its coexistence with traditional CV risk factors (i.e. obesity, insulin resistance, diabetes mellitus, dyslipidemia and hypertension). ABI is a simple and non-invasive tool used to diagnose peripheral arterial disease (PAD), an ABI of ≤0.9 is diagnostic of PAD and has shown to be an independent risk factor for CV disease and CV mortality. Currently, borderline ABI (0.91-0.99) is recommended to be considered as a CV risk factor. *Aim:* To describe the frequency of MASLD and altered ABI in patients with traditional CV risk factors.

Patients / Materials and Methods: An observational, descriptive, and cross-sectional study was performed, we included adult patients with CV risk factors (18 to 70 years old). The sociodemographic characteristics, alcohol consumption, drug usage, smoking and anthropometric measurements (height, weight, BMI, waist, hip and neck