

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 ($\chi^2 = 46.6$, $p < 0.0001$). (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.

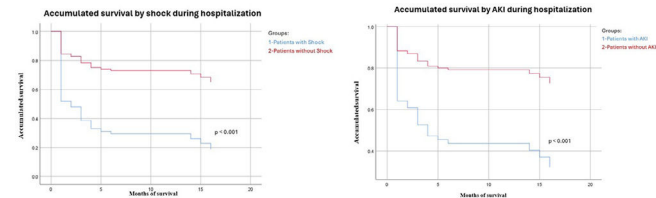


Figure 1

<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 PRE-DICTIVE VALUE, % (95% CI)	100	80 (68-92)	72.7 (59.4-86)	78.8 (66.6-91)
NEGATIVE PRE-DICTIVE VALUE, % (95% CI)	45.4 (30.1-60.3)	78.8 (66.6-91)	70 (56.3-83.7)	80 (68-92)

<https://doi.org/10.1016/j.aohep.2024.101720>

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