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.

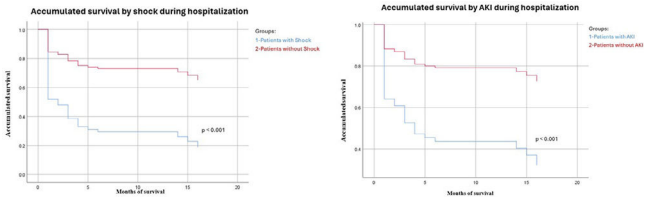

Figure 1

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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

circumference) were collected. ABI measurement was performed in all patients with a 8 mHz vascular doppler to classify patients as: Normal ABI (1.0-1.4), Altered ABI (≤0.9 or >1.4) and borderline ABI (0.91-0.99). Transient elastography (Fibroscan) was performed to determine steatosis and fibrosis stage. We excluded pregnant women, previously known CV disease, CLD or PAD. Descriptive statistics and comparative analysis were performed using SPSS version 24 software.

Results and Discussion: Sixty-eight patients with CV risk factors were included (48 female [70.6%] with a mean age of 47.38 years). Comorbidities were detected as follows: obesity in 52 patients (76.5%); dyslipidemia in 49 patients (72%); diabetes mellitus in 46 patients (67.6%); arterial hypertension in 35 patients (51.5%). Fifty-three patients had normal ABI (77.9%); altered ABI was found in 15 patients (22.1%). Sixty-one patients were found to have steatosis (89.7%), out of which 14 patients had fibrosis (22.9%). Comparison of both groups (altered vs. normal ABI) are presented in Table 1.

Conclusions: Patients with traditional CV risk factors showed a high rate of MASLD and similar altered ABI compared to previously described populations.

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P-108 MAFLD-S SCORE: A CONVENIENT CLINICAL TOOL FOR PREDICTING MASLD IN PRIMARY CARE SETTINGS

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Conflict of interest: No

Introduction and Objectives: Non-invasive methods for screening metabolic dysfunction-associated steatotic liver disease (MASLD) are gaining attention. A recent advancement in non-invasive screening is the MAFLD-S score, a tool that exclusively uses clinical data to predict the risk of MASLD.

The aim is to evaluate the performance of the MAFLD-S score to identify individuals with MASLD in a cohort of apparently healthy individuals.

Patients / Materials and Methods: A cross-sectional study was conducted including adults with unknown MASLD. A transient elastography was performed and hepatic steatosis was defined by a controlled attenuation parameter (CAP) > 248 dB/m. The MASLD criteria were assessed, and the MAFLD-S score, Fatty Liver Index (FLI) and Hepatic Steatosis Index (HSI) were calculated in each member of the cohort. The classification accuracy of these scores was evaluated through their areas under the receiver-operating characteristic (AUROC) curves and their calibration to predict the risk of MASLD was assessed graphically.

Results and Discussion: A total of 521 participants were included, being 61% women, and the mean age was 41 years. The frequency of MASLD in the study population was 44.1%. The area under the ROC curve for MAFLD-S was 0.823 (95% CI, 0.788-0.858), for FLI was 0.841 (95% CI, 0.807-0.875) and for HSI was 0.822 (95% CI, 0.787-0.858). The calculated sensitivity for MAFLD-S score using the recommended threshold was 61% (95% CI 0.55-0.68) and specificity of 81% (95% CI 0.77-0.86), for FLI sensitivity was 62% (95% CI 0.56-0.68) and specificity was 82% (95% CI 0.78-0.87) and for HSI sensitivity was 85% (95% CI 0.80-.89) and specificity was 61% (95% CI 0.56-0.67).

Conclusions: The MAFLD-S score, a tool that only uses clinical variables, confirmed to be a very good tool for screening MASLD in apparently healthy individuals in Mexico.

	Sensitivity	Specificity	+LR	-LR
Using recommended threshold				
MAFLD-S score	0.61 (0.55-0.68)	0.81 (0.77-0.86)	3.24 (2.50-4.20)	0.48 (0.40-0.57)
Fatty Liver Index	0.62 (0.56-0.68)	0.82 (0.78-0.87)	3.51 (2.67-4.60)	0.46 (0.39-0.55)
Hepatic Steatosis Index	0.85 (0.80-0.89)	0.61 (0.56-0.67)	2.19 (1.87-2.56)	0.25 (0.18-0.34)
Using optimal threshold in our study population				
MAFLD-S score	0.76 (0.70-0.81)	0.77 (0.72-0.81)	3.20 (2.60-4.04)	0.32 (0.25-0.40)
Fatty Liver Index	0.92 (0.89-0.96)	0.66 (0.61-0.72)	2.74 (2.32-3.24)	0.12 (0.08-0.19)
Hepatic Steatosis Index	0.72 (0.66-0.78)	0.76 (0.71-0.81)	3.00 (2.40-3.75)	0.30 (0.30-0.46)

Sensitivity and specificity for the thresholds recommended by each index and with the optimal threshold for our study population

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P-109 ALKALINE PHOSPHATASE AND CIRRHOSIS AT DIAGNOSIS ARE ASSOCIATED WITH DEEP RESPONSE TO URSODEOXYCHOLIC ACID IN PRIMARY BILIARY CHOLANGITIS

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