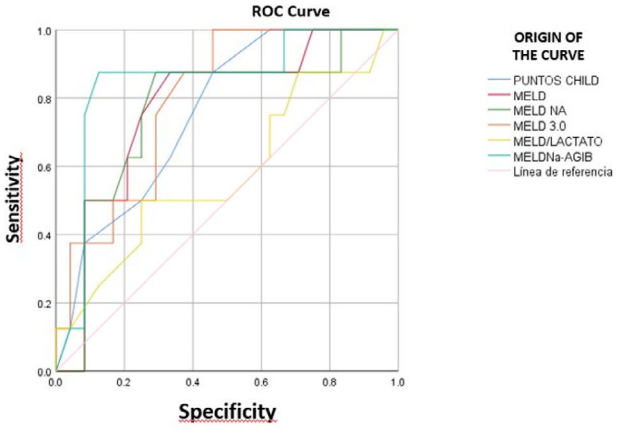
scoring system in predicting mortality among patients with variceal bleeding. A significance level of p<0.05 was considered, and sensitivity and specificity were determined based on the cutoff points obtained from the significant ROC curves.

Results and Discussion: A total of 32 patients were included in the study, of whom 56.2% were male, with an average age of 57±11. The etiologies of cirrhosis included alcohol-related, metabolic-associated fatty liver disease (MAFLD), dual injury, hepatitis C virus (HCV), autoimmune hepatitis (AIH), and unidentified causes (34.37%, 31.25%, 21.87%, 6.25%, 3.12%, 3.12%, respectively). Fifty percent of the patients had a prolonged QTc interval (>456ms) as calculated using the Fridericia formula, and 67.2% had a history of previous variceal hemorrhage. The MELDNa-AGIB scale demonstrated an area under the receiver operating characteristic (AUROC) curve of 0.849 (95% confidence interval: 0.681-0.950, p=0.004), with a sensitivity of 87.5% and specificity of 83% when a cutoff point of 17 was applied for MELDNa-AGIB. The AUROC for predicting mortality was significantly lower for MELD/Lactate.

Conclusions: Although the study group was small, the MELDNaAGIB scale showed significant performance in predicting 6-week mortality in patients who developed variceal hemorrhage.



AREA UNDER THE CURVE

TEST VARIABLES	Area	Desv. Error[b]	Asymptotic significance[b]	95% Asymptotic Confidence Interval	
				Lower limit	Upper limit
CHILD PUGH SCORE	0.758	0.089	0.031	0.584	0.932
MELD	0.776	0.094	0.021	0.592	0.960
MELD NA	0.766	0.102	0.026	0.566	0.965
MELD 3.0	0.797	0.080	0.013	0.639	0.955
MELD/LACTATE	0.583	0.124	0.486	0.341	0.826
MELDNa-AGIB	0.849	0.086	0.004	0.681	1.000

The test result variables: CHILD POINTS, MELD , MELDNa, MELD 3.0, MELD/LACTATE, MELDNa-AGIB have at least one tie between the positive true state group and the negative true state group.

a. Under the non-parametric assumption

b. Null hypothesis: true area = 0.5

Figure 1. Comparative analysis among different scales in patients with variceal hemorrhage and hepatic cirrhosis.

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P- 114 CLINICAL CHARACTERIZATION OF CIRRHOTIC PATIENTS HOSPITALIZED AT THE CARDIOINFANTIL FOUNDATION: A NEW PERSPECTIVE

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Conflict of interest: No

Introduction and Objectives: Cirrhosis is classically classified as compensated or decompensated in relation to the presence of ascites, variceal bleeding or encephalopathy. 5 stages of the course of the disease have been associated with the combination of these decompensations being the most advanced stages associated with higher mortality (60% per year). Acute-on-chronic liver failure (ACLF) can appear at any time during the course of the disease. Trying to understand the clinical course of cirrhosis, the PREDICT study established the CLIF-C AD score as a scale with greater sensitivity (>50 pts) to discriminate patients at high risk of developing ACLF with new trajectories of the course of cirrhosis: Stable and unstable decompensated cirrhosis; and pre-ACLF. Currently, there are no studies in Latin America that characterize the clinical outcomes in relation to the courses proposed by the PREDICT study. *Objectives:* Describe the demographic, clinical, paraclinical, management and outcomes in adult patients with cirrhosis, who have received medical care at the Cardioinfantil Foundation for any episode of decompensation in the period between 2015-2021

Patients / Materials and Methods: Historical cohort where exposure was defined as decompensated cirrhotic patients requiring hospital care during the period from 2015 to 2021. Descriptive statistics were used, and flow charts were used to indicate the distribution of patients.

Results and Discussion: Information was collected from 259 patients, mainly men (45%). Main etiologies of cirrhosis were MASH (18.9%), alcoholic (17%), cryptogenic (13.9%), and autoimmune hepatitis (12%). Patients mainly corresponded to the stable decompensated group (75%). The most frequent decompensation documented on admission was ascites in 66%, followed by hepatic encephalopathy in 41.3%. In the pre-ACLF group, mortality and renal dysfunction were higher.

Conclusions: Patients who present with decompensation of cirrhosis and who during their stay developed an infectious process associated with renal dysfunction and high CLIF C-AD scores are more likely to develop ACLF.

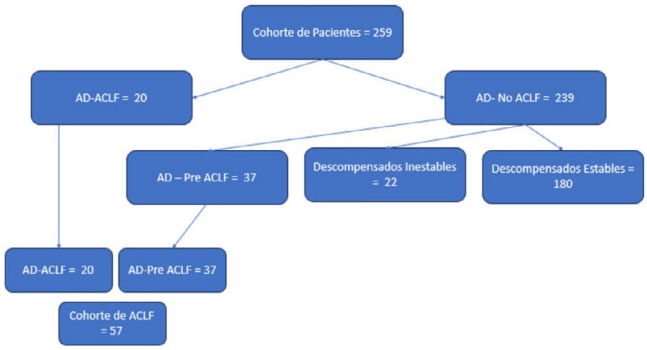
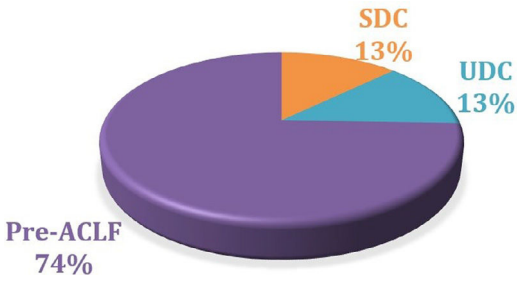


Figura 1



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