The objective is to present the case of a patient with ALF secondary to idiosyncratic DILI due to ibuprofen consumption.

Materials and Patients: A 43-year-old woman with no history of alcohol, herbal, or drug consumption. She presented with asthenia, adynamia, and unquantified fever, self-medicating with ibuprofen 1.2 g/day. Subsequently, she developed right hypochondrium pain and generalized jaundice without discontinuing ibuprofen. Four weeks after the onset of symptoms, she developed choluria, acholia, and hyporexia, with laboratory findings showing mild thrombocytopenia (platelets 109,000 u/L), transaminasemia (aspartate aminotransferase 890 U/l, alanine aminotransferase 1183 U/l, alkaline phosphatase 311 U/l), direct hyperbilirubinemia (total bilirubin: 7.8 mg/dl, direct: 6.8 mg/dl), and prolonged prothrombin time. Hepatotropic virus and HIV infections were ruled out, as well as autoimmune liver diseases. Hepatic ultrasound showed a starry sky pattern and splenomegaly. Magnetic resonance cholangiopancreatography revealed only hepatosplenomegaly. Liver biopsy showed intense inflammation with polymorphonuclear and lymphocytic infiltrate, total acinar involvement, cholestasis, and hepatocellular necrosis, compatible with acute severe hepatitis and accentuated cholestasis probably secondary to DILI. Management with ursodeoxycholic acid and prednisone (50 mg/day) was initiated without improvement, with a torpid evolution due to the development of hepatic encephalopathy, coagulopathy, and upper gastrointestinal bleeding.

Results: DILI has an estimated annual incidence of 2.5 cases/100,000 inhabitants, considered a diagnosis of exclusion, with complementary studies useful to increase diagnostic suspicion. In this context, the R factor should be calculated to characterize the type of liver injury. Liver biopsy is useful and shows three patterns: necroinflammatory, cholestatic, and mixed. Idiosyncratic reactions occur in susceptible individuals, are dose-independent, and mostly occur 5-90 days after drug intake. Ibuprofen is associated with a mixed pattern in this presentation. DILI is one of the main causes of ALF, defined by the appearance of hepatic encephalopathy between 7-28 days after the onset of jaundice, with coagulopathy and moderate elevation of transaminases and bilirubin. In this case, a woman with no history of liver disease, recent ibuprofen intake, and acute liver damage was observed. During her evaluation, alcoholic, infectious, and autoimmune pathologies were ruled out, revealing a mixed pattern of liver injury (necroinflammatory and cholestatic) on imaging and histopathological studies. In patients with ALF secondary to DILI, early liver transplantation should be considered due to the high risk of irreversible damage and complications.

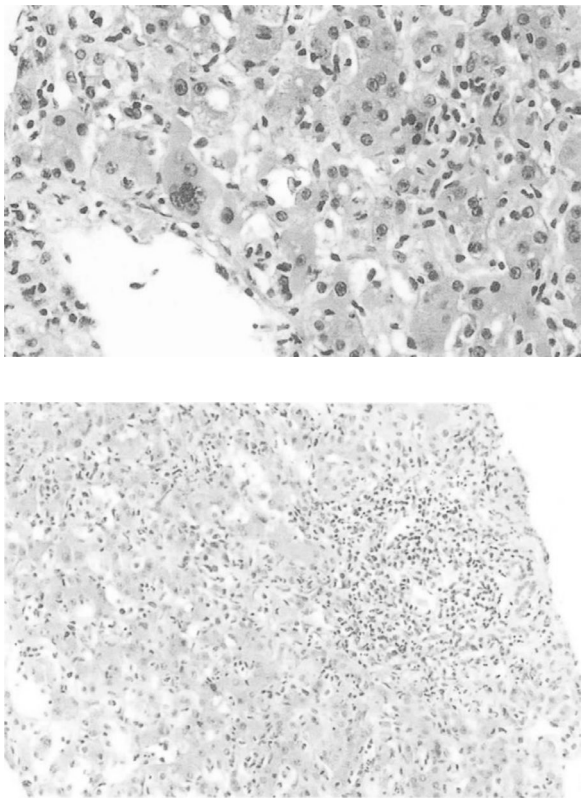
Conclusions: In patients with recent-onset liver failure, it is essential to rule out recent drug intake that may cause DILI to detect it early and initiate timely supportive management, considering liver transplantation due to the high risk of associated complications.

Ethical Statement: This case report has been prepared following the highest ethical standards and respecting the principles of integrity and transparency. All relevant ethical guidelines have been followed, ensuring the privacy and confidentiality of the individuals involved.

Conflict of Interest: None.

Funding: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Figure 1. Liver biopsy from the patient



Giant cells, cholestasis, Kupffer cells and hepatocelular necrosis were identified

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Acute Liver Failure: Cohort of patients treated at the La Raza National Medical Center Specialty Hospital.

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Introduction and Objectives: Identify the clinical, biochemical behavior, complications and mortality of patients with acute liver failure admitted to the hospital.

Materials and Patients: A descriptive, cross-sectional and retrospective observational study was carried out on all patients who entered the gastroenterology service of the CMN La Raza Specialty Hospital from April 2022 to April 2024 with a diagnosis of Acute Liver Failure. Information was taken from the electronic medical, radiological and laboratory care records. Taking demographic data, clinical and biochemical behavior of the patients, the presence of complications, comorbidities and the outcome. The results were analyzed using measures of central tendency to obtain percentages and arithmetic mean.

Results: 78 patients admitted to the service in this period were registered, of them 11 women (14%) and 67 men (85.4%). The average age was 34.7 years (18-64 years). The most frequent cause was attributable to Hepatitis A virus (61%), autoimmune hepatitis (9.75), acute fatty liver of pregnancy (7.3%); However, in 9.7% of patients, no cause was determined (Graphic 1). More than half of the patients presented without other comorbidity (58.5%). Of the patients with comorbidities, Systemic Arterial Hypertension was the most frequent in 17%. The most frequent complications were acute kidney injury (78%), ascites (14.6%), metabolic acidosis (14.6%); upper gastrointestinal bleeding (12.1%) and diffuse cerebral edema (9.7%). Some patients required some type of renal function replacement therapy, such as Hemodialysis (19.5%). 7.3% required therapy with PRISMA and 34.1% with MARS. Mortality is significant in 48.7% of patients despite therapy. Of the patients, 28.2% met transplant criteria, and only 25% of these were transplanted (Table 1).

Conclusions: We have noticed an increase in the incidence of Acute Liver Failure in general, highlighting this in young patients of economically productive age and reproductive age, which emphasizes enhancing prevention campaigns in vaccination against virus A in this population, being the cause, of more frequent in our cohort.

Ethical statement: Information taken from electronic files without data that invades privacy; therefore, ethical conflicts are not generated.

Declaration of interests: None.

Funding: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

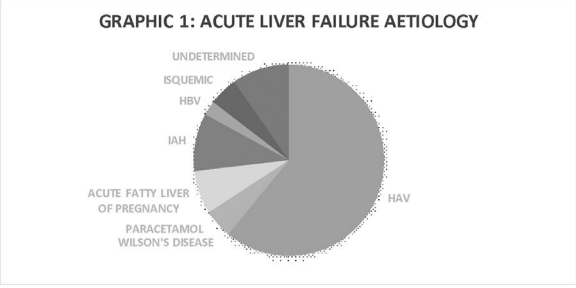

Table 1
Demographic data of the population

SEX	
WOMEN	13 (31.7%)
MEN	28 (68.3%)
AVERAGE AGE	34.7 YEARS OLD (18-64 AÑOS)
COMORBILITIES	NONE 58.5%
	17%
COMPLICATIONS	ACUTE KIDNEY INJURY78%
	ASCITES 14.6%
	METABOLIC ACIDOSIS 14.6%
	DIGESTIVE HEMORRHAGE12.2%
	BRAIN EDEMA 9.7%

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Prevalence of fibrosis and steatosis determined by transient elastography and controlled attenuation parameter (Fibroscan®) in diabetic patients

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Introduction and Objectives: Globally, a higher prevalence of metabolic dysfunction-associated fatty liver disease (MAFLD) has been reported in diabetics (55.5%) compared to the general population (25%). In Mexico, there is a lack of studies on diabetes (DM2) in this subgroup. Objective: To determine the prevalence of hepatic fibrosis and steatosis determined by FibroScanâ in patients with DM2.

Materials and Patients: An observational, descriptive, cross-sectional study included patients who attended the clinic for DM2 between August 2018 and March 2024 and underwent FibroScan® to determine the absence/presence and degree of fibrosis and steatosis. Patients were excluded if they had risky alcohol consumption, hepatitis B/C, any type of previously diagnosed hepatopathy or cirrhosis, or consumption of medications other than those for metabolic syndrome (MS). Descriptive statistics were used, and the prevalence of FibroScan® determined steatosis and fibrosis was estimated.

Results: A total of 298 patients were evaluated, 195 (64.5%) women, with a mean age of 55.6±10.8 years. Of these, 284 (95.3%) agreed to undergo FibroScan® examination, none had risky alcohol consumption, 146 (51.4%) were smokers, 114 (40.1%) were overweight, 75 (25.6%) had grade I obesity, 34 (12%) had grade II obesity, and 14 (4.9%) had grade III obesity. 106 (56.3%) were hypertensive, 177 (62.3%) had dyslipidemia, and 168 (59.2%) met the criteria for MS. Regarding the FibroScan® parameters, 109 (38.4%) had steatosis: S1 in 34 (12%), S2 in 33 (11.6%), and S3 in 42 (14.8%). There was fibrosis in 155 (56.4%): F1 in 42 (14.8%), F2 in 40 (14.1%), F3 in 26 (9.2%), and F4 in 47 (16.5%). The biochemical parameters of this cohort are shown in Table 1. There was no relationship between the duration of DM2, the stage of disease control, recent adherence to treatment, and the presence or stage of steatosis or fibrosis (p=N.S.).

Conclusions: The prevalence of MASLD associated steatosis and fibrosis is high in Mexican diabetic patients and occurs independently of disease control, disease duration, and recent adherence to treatment.

Ethical Statement: This study was conducted following the principles and ethical standards of our institution in accordance with the Declaration of Helsinki.

Declaration of Interests: None.

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Table 1
Biochemical Characteristics of the Cohort of Patients with Diabetes.

Variable	Mean (± Standard Deviation)	Range
Glucose (mg/dL)	129 ± 48	51 – 360
HbA1c (%)	7.42 ± 2	4 – 16.7
Creatinine (mg/dL)	0.88 ± 0.46	0.4 – 4.08
Aspartate Aminotransferase (U/L)	28 ± 18.5	10 – 180
Alanine Aminotransferase (U/L)	29.5 ± 20.3	8.8 – 139
Gamma-glutamil transferase (U/L)	61.5 ± 79.2	9 – 508
Body Mass Index (kg/m^2)	29.88 ± 5.07	18.88 – 48.99
Triglycerides (mg/dL)	185.9 ± 147.8	40 – 1385
Total Cholesterol (mg/dL)	172.42 ± 44.24	39 – 295
High Density Lipoproteins (mg/dL)	44.56 ± 12.65	2 – 132
Low Density Lipoproteins (mg/dL)	104.46 ± 35	22 – 230

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