presented fever higher than 39°°C and is accompanied by itching predominantly in the extremities. For this reason we decided to carry out a diagnostic approach in our unit, where complementary studies are carried out that included BHC, QS, ES, PFH, these being the only resources our unit has.

Results: We evaluated a patient who attended a rural unit due to generalized erythema, fever and scaly lesions that occurred in the first 90 days after starting treatment with Dotbal, and was also accompanied by pruritus, fever and jaundice with data compatible with febrile erythroderma or DRESS syndrome (Drug Reaction with Eosinophilia and systemic symptoms), once this dermatological diagnosis was established, we proceeded to evaluate laboratory studies and evidenced data of DILI (Drug Induced Liver Injury) with a hepatocellular pattern, elevated transaminases more than 10 times their normal value, complying 6 points of RUCAM criteria for DILI and with an R factor of 9 points. During his hospitalization he progressed to acute kidney injury and medications were immediately discontinued. Hemodynamic support treatment was given and he is currently in the recovery phase. Exposure to isoniazid, a drug that has been described as a producer of DRESS and DILI, was established as the causal agent.

Conclusions: We present the case of care in a rural hospital, where resources are low. The importance corresponds to identifying the coexistence of DRESS and DILI, this action allows timely management and avoids serious complications of these diseases such as shock and acute liver failure.

Ethical statement: The authors declare that the article is unique, it has not been previously published in any other media services and there are informed consents signed by the participants and the patient for their participation in the hepatology congress held by the AMH 2024.

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.

IMAGE 1:

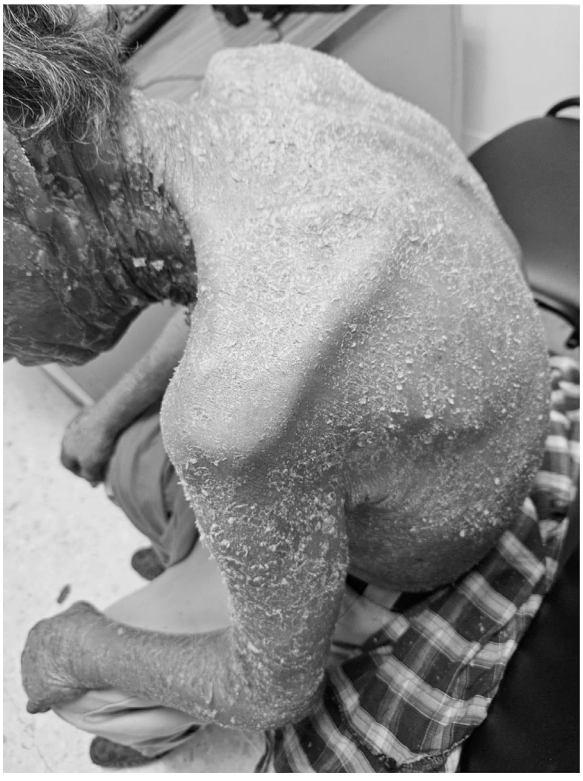

Table 1
Laboratory values before and three months after treatment

Laboratories	Start Treatment	Three months after treatment
Hemoglobine	11g/dl	10.5g/dl
Platelets	490,000	150,000
Leukocytes	6900	5300
Total bilirubin	0.8 mg/dl	3mg/dl
Direct bilirubin	0.5 mg/dl	2.5mg/dl
Indirect Bilirubin	0.3 mg/dl	0.5mg/dl
ALT	9 UI	399 UI
AST	10 UI	203 UI
ALBUMIN	3.0g/dl	1.7 g/dl
ALKALINE PHOSPHATASE	218UI	369UI
GGT	102UI	155UI
DHL	359U	377U
BUN	6.8mg/dl	14 mg/dl
UREA	14 mg/dl	30 mg/dl
CREATININE	0.4 mg/dl	1.2 mg/dl

https://doi.org/10.1016/j.aohep.2025.101832

Adverse effects of the use of terlipressin infusion compared to boluses in patients with liver cirrhosis and variceal hemorrhage. TERMEX study.

Luis R. Antuna-Villaseñor, Germán A. Roman-Lugo, Jose Pérez-Sánchez, Alexis E. Chavarín-Meza, Yvonne Tadeo-Jiménez, Rosalba Moreno-Alcántar, Aleida Bautista-Santos

Specialties Hospital, National Medical Center Siglo XXI. IMSS, Mexico

Introduction and Objectives: Cirrhosis is a worldwide health problem as it is a leading cause of mortality. The development of complications in cirrhosis is directly related to the presence of portal hypertension. The risk of annual variceal hemorrhage is 5% for small varices and 15% for large varices. Terlipressin represents a useful drug for this group of patients; classically it has been used in bolus but recent studies have shown that its use in infusion may be superior in bleeding control and with fewer adverse effects. The aim of this study is to define whether there are fewer adverse effects with the use of terlipressin infusion compared to bolus.

Materials and Patients: We include patients in the care of the gastroenterology department from July to December 2023 who met the inclusion criteria were included: >18 years, diagnosed with liver cirrhosis and variceal hemorrhage, who had received terlipressin infusion or bolus. Statistical analysis: descriptive statistics, frequencies and percentages were calculated with Student's t and Mann-Whitney U according to the distribution of the variables; Student's t was used to show differences between groups and chi-square to determine the risk of adverse events with bolus respect terlipressin infusion. Wilcoxon test was applied to show differences between groups.

Results: 58 patients were included, all received endoscopic treatment in addition to terlipressin: 16 patients received infusion (27.6%) and 42 (77.4%) received terlipressin in bolus. Female gender predominated with 30 (51.7%), mean age was 55.8 ±10.93 years; the most frequent etiologies of liver cirrhosis were: (MASLD) steatotic liver disease associated with metabolic dysfunction 19 (32.8%), primary biliary cholangitis 12 (20.7%) and MASLD with significant alcohol consume (MetALD) 8 (13.8%). The median MELD was 16 (12-20) points, and the median Child-Pugh Turcotte score was 7 (6-9). Rebleeding occurred in 8 (13.8%) patients and one patient required rescue TIPS (transjugular portosystemic shunt). The percentage of adverse effects was 27.6% (n=16) and therapy was changed to

octreotide in 15 (25.9%) patients. The bolus group had 31% (n=13) adverse effects compared to the infusion group where only 3 (18%). The main adverse effect was abdominal pain in 15.5% (n=9). Mortality was 6.9% in our study(n=4).

Conclusions: Adverse effects of terlipressin infusion compared to bolus had no significant difference in the group analyzed. However, there is a tendency in favor of infusion since only 3 patients had adverse effects, we consider that by increasing the sample size, there could be difference in favor of the infusion group.

Ethical declaration: The authors declare that the TERMEX study was submitted to hospital ethics committees, has not been previously published and its publication is authorized by all authors. All of them participated in its preparation to a sufficient extent to be responsible for its content, which is true, not duplicated, without fraud or fabrication.

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. Characteristics of patients with cirrhosis and variceal bleeding.

	n= 58
Women, No. (%)	30 (51)
Age, years, mean, SD.	55.8 (±10.93)
BMI kg/m, mean, SD	25.8 (±4.19)
Child Pugh median, percentiles	7(6-9)
MELD median, percentiles	16 (12-20)
Diabetes mellitus (%)	24 (41.4)
Etiology (%)	
MASLD	19(32.8)
Primary biliary cholangitis	12(20.7)
MetALD	8(13.8)
ALD	5 (8.6)
Chronic HCV infection	4 (6.9)
Other	11 (17)
Total bilirubin µmol/L median, percentiles	1.61 (0.96-2.06)
Sodium mEq/L median, percentiles	137 (136-139)
Albumin g/dL, median, percentiles	2.7 (2.15-3.2)
INR median, percentiles	1.41(1.25-1.63)
Creatinine mg/dL, median, percentiles	0.86 (0.70-1.13)
Smoking (%)	24 (41.4)

SD=standard deviation. BMI=body mass index MASLD: metabolic dysfunction-associated steatotic liver disease ALD: alcoholic liver disease MetALD: MASLD plus heavy alcohol consumption.

https://doi.org/10.1016/j.aohep.2025.101833

Liver donor with hepatitis c virus false positive in negative recipient. A case report

Yenni J. Cruz-Ramírez, Reina S. Velez-Ramírez, Fancisco I García-Juarez, Norma N. Parra-Holguin

Mexican Society of Gastroenterology & Mexican Association of Hepatology, México

Introduction and Objectives: The growing disparity that exists between the number of available donors and patients on the waiting list, transplant centers have presented initiatives to take into account patients diagnosed with hepatitis C virus (HCV), the objective of liver transplantation being the extension of the patient's life.

Materials and Patients: 62-year-old female patient, with a diagnosis of liver cirrhosis diagnosed in 2012, secondary to primary biliary cholangitis (PBC). Evaluated in August 2023, a clinical approach was performed identifying uncontrolled liver cirrhosis, reporting in the last year she had three episodes of hepatic encephalopathy West Haven (WH) II and III, plus two events of upper gastrointestinal bleeding secondary to grade III esophageal varices performing 3-bundle variceal ligation, prognostic scales were calculated, Child Pugh B 8 points, MELD NA 15 POINTS, biochemistry: TORCH negative, profile for non-reactive hepatitis A, B and C viruses, non-reactive human immunodeficiency virus (HIV), positive PPD purified protein derivative skin test, evaluated by infectious disease who reports that he has latent tuberculosis with a plan to start treatment. Liver sonographic ultrasound (USG) was performed, reporting chronic liver disease, ascites, no portal hypertension, magnetic resonance imaging (MRI) of the liver: reported diffuse chronic liver disease, no evidence of tumor activity, ascites, decompensated portal hypertension, panendoscopy reported Dagradi III esophageal varices plus ligation of 3 variceal bundles. The liver transplant protocol is completed and presented to the liver transplant (LT) committee, referring the patient to be enlisted to be a liver recipient.

Results: Anti HCV 1.40 S/40 CO= REACTIVE Viral load of hepatitis c virus: RNA not detected.

Conclusions: In the following case, the donor presents positive antibodies for hepatitis C virus, a viral load is done reporting undetectable RNA, considering a false positive result, it is emphasized that if positive, there is no contraindication for the transplant, since previous studies have shown results similar to those of organ transplantation from HCV negative donors.

Ethics statement: Protection of people and animals: The authors declare that no experiments have been carried out on humans or animals for this research. **Data confidentiality**: The authors declare that no patient data appear in this article. **Right to privacy and informed** consent: The authors declare that no patient data appears in this article.

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

Declaration of interests: None.

https://doi.org/10.1016/j.aohep.2025.101834

Evaluation of oxidative stress according to the pattern of alcohol consumption and in alcoholic liver disease.

Adrián Flores-Sánchez[1], Abigail Hernández-Barragán[1], Daniela Colector-Sesatti[1], Andrea Garcia-Avalos[1], Moisés Martínez-Castillo[1], Marisela Hernández-Santillan[1], Jaqueline Córdova-Gallardo[3], José L. Pérez-Hernandez[2], Fátima Higuera-De la Tijera[2], Gabriela Gutiérrez-Reyes[1]

[1] *Liver, Pancreas, and Motility Laboratory (HIPAM), Experimental Medicine Research Unit, Faculty of Medicine, UNAM, General Hospital of Mexico, Dr. Eduardo Liceaga, Mexico*
[2] *General Hospital of México Dr. Eduardo Liceaga, Mexico*
[3] *Dr. Manuel Gea González General Hospital, Mexico City, Mexico*

Introduction and Objectives: Alcohol and its metabolites induce damage in the liver, such as: activation of the immune response and oxidative stress. Objective: To evaluate the redox state through markers of oxidative stress in patterns of alcohol consumption and alcohol-related liver disease (ALD).

Materials and Patients: A cross-sectional and multicenter study was conducted, with the inclusion of individuals displaying various patterns of alcohol consumption. Participants were categorized based on responses to questionnaires (AUDIT and DSM-IV), as well as an individualized survey, along with clinical and biochemical data. Six distinct groups were established: Risk (RI), Abuse (Ab), Alcoholism (OH), as well as ALD: alcohol liver cirrhosis (CiOH) and alcoholic hepatitis (HA), in addition to a control group (CT). Stress markers, including reduced glutathione (GSH) and oxidized glutathione (GSSG), were assessed in peripheral blood and we calculated GSH/GSSG ratio, lipid peroxidation via malondialdehyde formation, and protein oxidized by carbonylated protein were quantified. Statistical analysis