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Introduction and Objectives: Patients with cirrhosis who require hospitalization due to acute decompensation (ascites, digestive bleeding, hepatic encephalopathy, among others), have a variable adverse prognosis, depending on whether they have acute-on-chronic liver failure (ACLF), the CLIF-C AD test allows to identify the risk of readmission, development of ACLF and mortality.

Materials and Patients: A cross-sectional study was carried out between October 2023 and May 2024. The CLIF-C AD test was calculated in patients with decompensated cirrhosis. The results were analyzed using descriptive statistics, frequency analysis, and percentages. Group comparison analysis was performed with Student's T and chi square as appropriate, to determine the sensitivity and specificity of this test, and a ROC curve was performed; Likewise, Kaplan Meyer curves of 2 groups were used according to the CLIF-C AD categorized as 62 or less and greater than 62; having a significant value of p:0.005; The analysis was performed with the statistical program SPSS version 25.

Results: There were 40 patients; 32 men and 8 women. Cirrhosis etiology: alcohol 30 patients (75%), MASLD 8 patients (20%), autoimmune hepatitis 2 patients (5%). Cause of decompensation: Upper digestive bleeding in 19 patients (47.5%), urinary infection in 8 patients (20%), tense ascites in 4 patients (10%), spontaneous bacterial peritonitis in 3 patients (7.5%). Findings on admission: ascites 27 patients (67.5%), hepatic encephalopathy 27 patients (67.5%), shock 18 patients (45%). The CLIF-C-AD score with a median of 68 IQR (52-73). Readmission 35 patients (87.5%); The cause of readmission was hepatic encephalopathy in 17 patients (42.5%), upper digestive bleeding in 10 patients (25%), and acute kidney injury in 3 patients (7.5%). Using Student's T, the CLIF-C AD score is determined for those who were readmitted with a mean of 66 and for those who were not readmitted with a mean of 41 ($p<0.001$). In the ROC curve, the area under the curve was found to be 0.950 with 95% CI (0.890-1.000) p=0.001, sensitivity 77%, specificity 100%, with a Youden point of 62 points; Therefore, it is categorized into 2 groups based on this score for a cumulative incidence of readmission by Kaplan Meier curve, showing a difference between the groups with a Log Rang test of 0.005.

Conclusions: The CLIF-C AD score is a practical, adequate, and useful tool to determine the outcome of decompensated cirrhotic patients, which will allow the identification of high-risk patients and the implementation of close follow-up strategies and timely therapeutic adjustment and avoid adverse outcomes. More studies are required and increased sample size.

Ethical statement: This protocol was registered and approved by the ethics committee. Patients' identities are protected. Consent was obtained.

Declaration of interests: None.

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Association between autoimmune hepatitis and leukocytoclastic vasculitis, a case report

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Introduction and Objectives: Autoimmune hepatitis has an incidence that ranges from 0.9-2%. It is usually associated with other liver diseases and other autoimmune disorders, however, there are few cases associated with leukocytoclastic vasculitis. Now we present the case of an association between autoimmune hepatitis and leukocytoclastic vasculitis.

Materials and Patients: This is a female patient who presented constant pain in the right hypochondrium since 2019, intermittent fever with nocturnal presentation.

In the Personal pathological history, she reported that was healthy, had an uncomplicated pregnancy, had no history of traveling outside the country or visiting caves, had no family history of autoimmune, genetic, or infectious diseases, had no history of exposure to chemical substances or people with a diagnosis of tuberculosis. During the years 2019 to 2024, in addition to pain in the hypochondrium and fever, they presented myalgia, arthralgia, morning stiffness that improves with activity with signs of inflammatory pain, facial erythema, and maculopapular skin rashes on the hands and legs on sun exposure. She presented Eye with foreign body sensation, and we referred to rheumatology, considering the possibility of systemic lupus erythematosus and Sjögren's syndrome, complementary studies were performed, and she was sent to ophthalmology where a normal tear breakup time of less than 5 seconds was concluded. and Sjögren's Syndrome is ruled out. Antibodies are performed to rule out systemic lupus erythematosus, such as Anti DNA and Anti SM, being negative.

Results: We performed a diagnostic approach in a patient with constitutional symptoms, skin rashes and constant pain in the right upper quadrant. Complementary imaging studies were requested such as USG of the liver and CT scan of the abdomen, both of which showed signs of cirrhosis, so autoimmune hepatitis began to be suspected. Within the liver studies, the transaminases are normal, alkaline phosphatase elevated, and hyperglobulinemia. Protein electrophoresis with immunofixation was performed, being positive for HyperGammaglobulinemia, subsequently, biopsies of the lip, liver and skin lesions were taken. Amylodosis and Sjögren's syndrome were ruled out with these studies, however the skin lesions demonstrated leukocytoclastic vasculitis and the antibody studies showed positive ANA, with AMA, ANCA, DNA, SM negative, and the liver biopsy showed findings related to autoimmune hepatitis. Therefore, by ruling out connective tissue and associated oncological diseases, the diagnosis of autoimmune hepatitis was established, since when using the simplified diagnostic criteria of the International Autoimmune Hepatitis Group, 8 points were met, thus confirming the diagnosis of this entity. Due to hypergammaglobulinemia, hematological diseases were ruled out when bone marrow aspiration and biopsy were performed.

Conclusions: We did the approach of cirrhosis of unknown origin. We proceeded to look out autoimmune liver diseases, connective tissue and oncological diseases all of that were ruled out. Reaching the diagnosis required the commitment of several specialties: internal medicine, rheumatology, hematology and pathological anatomy.

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.

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Table 1

Laboratories Studies	Result
HIV, HBV, HCV	NEGATIVE
ANTI SMOOTH MUSCLE ANTIBODY	NEGATIVE.
ANTI MITOCHONDRIAL ANTIBODY	
ANCA P & ANCA C	
ALPHA FETOPROTEIN	NEGATIVE.
ANTIBODY OF CARCINOEMBRYONIC	
CA 19.9	
CA 125	
ANA	POSITIVE: 1:80, GRANULAR PATTERN.
ANTI RHO	POSITIVE, 27.1
ANTI LA	NEGATIVE.
BETA 2 MYCROGLOBULINE	1123
C3	187
C4	27
TSH Y T4-L	NORMAL.
IGA	916
IGM	223
IGG	3362
ANTI CCP	NEGATIVE
RHEUMATOID FACTOR	5.1
VSG, PCR.	NORMAL.

ANCA P & ANCA C, perinuclear & cytoplasmic anti-neutrophil cytoplasmic antibodies; ANA, antinuclear antibody; ANTI CCP, anti-cyclic citrullinated peptide antibody; ANTI LA, anti-La antibody; ANTI MITOCHONDRIAL ANTIBODY, anti-mitochondrial antibody; ANTI RHO, anti-Ro antibody; ANTI SMOOTH MUSCLE ANTIBODY, anti-smooth muscle antibody; ANTIBODY OF CARCINOEMBRYONIC, carcinoembryonic antigen; BETA 2 MYCROGLOBULINE, beta-2 microglobulin; CA 125, cancer antigen 125; CA 19.9, cancer antigen 19-9; C3, complement component 3; C4, complement component 4; FACTOR REUMATOIDE, rheumatoid factor; HBV, hepatitis B virus; HCV, hepatitis C virus; HIV, human immunodeficiency virus; IGA, immunoglobulin A; IGG, immunoglobulin G; IGM, immunoglobulin M; PCR, polymerase chain reaction; TSH Y T4-L, thyroid-stimulating hormone and free thyroxine; VSG, erythrocyte sedimentation rate.

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Liver Injury Induced by Peumus boldus with Fatal Outcome. Case Report

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Introduction and Objectives: Peumus boldus is a plant native to South America traditionally used to treat gastrointestinal ailments. There are reports of hepatotoxicity from prolonged consumption. We describe the case of a patient with liver damage induced by Peumus boldus, with a torpid evolution and fatal outcome, highlighting the awareness of the adverse effects of this plant.

Materials and Patients: A 48-year-old woman with a history of type 2 diabetes on insulin glargine treatment and a surgical history of cholecystectomy 12 years prior for cholelithiasis, without other relevant history. She began three weeks prior with asthenia, adynamia, hyporexia, nausea, fever, jaundice, and right hypochondrial pain. Upon questioning, exposure to an herbal supplement based on Peumus boldus during the previous 15 days was related. Upon admission with vital signs BP: 101/82 mmHg, HR: 98 bpm, RR: 21 rpm, Temperature: 38.2°C, SaO2 90%. On physical examination, generalized jaundice, dark urine, and pale stools were noted. Laboratories showed a cholestasis clinical pattern (R Factor of 1.0, with ALT of 62 U/L, ALP of 184 U/L). Despite discontinuing the herbal supplement, she progressed with progressive cholestasis on follow-up, leading to the initiation of glucocorticoids without improvement. Complementary studies were conducted, ruling out infectious and autoimmune diseases, as well as a transjugular liver biopsy reporting non-alcoholic steatohepatitis with morphological data of toxic-induced lesions with moderate activity.

Results: During her clinical course, with persistence of generalized jaundice and right hypochondrial abdominal pain, grade 2 ascites, and encephalopathy characterized by disorientation in time and circumstance, behavioral alterations, and eventually somnolence tendency, for which she was brought by family members to the emergency service of our hospital. During her hospital stay, she showed a tendency to hypotension, without adequate response to vasopressor treatment, with clinical and laboratory evidence of renal function deterioration, and worsening liver function parameters with BT of 22.1 mg/dl, DB 20.5 mg/dl, IB 1.6 mg/dl, ALT 64 U/L, ALP 188 U/L, Platelets 59,000 cells/mm3, PT 27.5 seconds, and INR 2.54. After 65 days from the onset of symptoms, despite the treatment used, a fatal outcome occurred.

Conclusions: Despite a growing number of reports of hepatotoxicity induced by Peumus boldus, it is not listed in databases intended for such purposes as LiverTox. This case highlights the importance of raising awareness about the hepatotoxic risks of herbal products.

Ethical Statement: This clinical case was prepared following current ethical standards and principles in medical research. Informed consent was obtained from the patient's legal representative for the anonymous publication of her clinical data. Confidentiality and respect for the patient's privacy were always guaranteed, according to the provisions established in the Declaration of Helsinki and the guidelines of the Ethics Committee of the General Hospital ISSSTE, Querétaro. No experimental interventions were performed, and all therapeutic measures applied were part of the standard of medical care.

Declaration of Interests: None.

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Characterization and determination of prevalence in autoimmune liver diseases in a tertiary center.

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Introduction and Objectives: Autoimmune Hepatic Diseases (AHD) involve a chronic immunomediated response towards hepatocytes and bile ducts, as seen in Primary Biliary Cholangitis (PBC), Autoimmune Hepatitis (AIH), and Primary Sclerosing Cholangitis (PSC). Their complex diagnosis, lack of studies, and irreversible liver damage pose significant challenges today due to increased mortality.

Materials and Patients: A retrospective (cross-sectional, retrolective) study was conducted. Patient records from men and women aged 18 and above attending the Liver Clinic from 2020 to 2023 were analyzed. Data included demographic, clinical, biochemical, serological, and histological variables compatible with EHAI diagnosis. Descriptive statistics such as frequency, percentages, measures of central tendency, and dispersion were employed for qualitative and quantitative variables.

Results: The prevalence of AHD during the evaluated period was 11.5% in our population. A total of 201 patients were identified, comprising 85 (42%) with PBC, 65 (32%) with AIH, 7 (4%) with PSC, and 44 (22%) with overlap (Figure 1). Among them, 177 (88%) were female.