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Introduction and Objectives: The natural history of MetALD remains poorly characterized. In a large global cohort, we compared the natural history of the main steatotic liver disease (SLD) subtypes in terms of liver fibrosis progression and hepatic decompensation.

Materials and Methods: Retrospective cohort study of adult participants with SLD (2003–2025), including MASLD, MetALD, and ALD according to the 2023 SLD criteria. Sociodemographic and clinical data, vibration-controlled transient elastography (VCTE) parameters, and liver biopsy (when available) were recorded. Other causes of liver disease were excluded. The primary outcome was progression to cirrhosis in those without cirrhosis at baseline (defined by 1. liver biopsy, or 2. VCTE ≥ 13.6 kPa, or Fibrosis-4 [FIB-4] > 3.25 if other techniques were missing). Secondary outcomes included incidence of hepatic decompensation (ascites, hepatic encephalopathy, variceal bleeding, or hepatorenal syndrome). A multivariable Cox regression adjusted by age, sex, race, body mass index, diabetes, hypertension, hyperlipidemia, and smoking (for HCC) was performed.

Results: The total cohort included 150,306 participants from 15 countries; 87.5% MASLD, 7.9% MetALD, and 4.6% ALD. Overall, the median age was 61 years [IQR 51–70]; 52.8% men, and 97.6% Asian. At baseline, 12.2% of the cohort had a liver biopsy with F4 or a VCTE/FIB-4 suggestive of cirrhosis. During a median follow-up of 2.1 years [IQR 0.6–4.7], 0.9% of participants progressed to cirrhosis and 0.4%

had hepatic decompensations. Individuals with MetALD and ALD exhibited a higher risk of progression to cirrhosis (MetALD aHR 1.34, 95%CI: 1.06–1.68, $p=0.013$; ALD aHR 1.82, 95%CI: 1.41–2.35, $p<0.0001$; MASLD: reference) and of hepatic decompensation (MetALD aHR 9.33, 95%CI: 6.32–13.75, $p<0.0001$; ALD aHR 20.56, 95%CI: 13.86–30.48, $p<0.0001$).

Conclusions: In this multi-ethnic global cohort, MetALD and ALD were associated with more rapid cirrhosis progression and greater decompensation rates than MASLD, independent of cardiometabolic factors.

Conflict of interest: None

Figure Cumulative Incidence of Cirrhosis by SLD Subtype

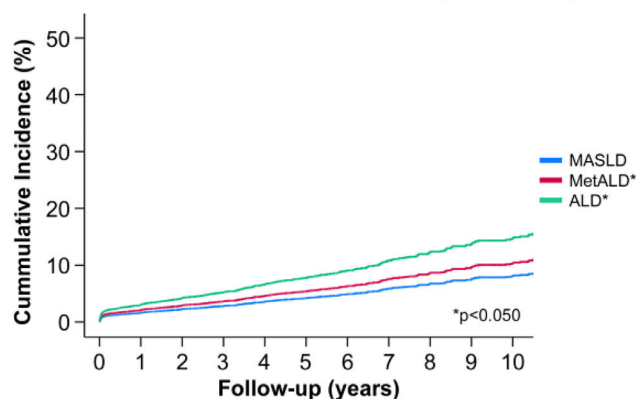


Figure. Cumulative incidence of incident cirrhosis by steatotic liver disease subtype. Participants with baseline cirrhosis—defined by (1) histologic stage F4, (2) liver stiffness ≥ 13.6 kPa on vibration-controlled transient elastography, or (3) Fibrosis-4 index > 3.25 —were excluded. Cox models were adjusted for age, sex, race, body mass index, diabetes, hypertension, and hyperlipidemia.

<https://doi.org/10.1016/j.aohep.2025.101952>

#14

FACTORS ASSOCIATED WITH HEALTH LITERACY IN PATIENTS DIAGNOSED WITH LIVER CIRRHOSIS IN COLOMBIA

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Introduction and Objectives: Health literacy (HL) refers to a patient's ability to obtain, process, and understand medical information needed to make informed health decisions. Low HL is associated with increased healthcare costs, higher hospitalization rates, reduced access to transplantation, and increased mortality—especially among vulnerable populations. In patients with cirrhosis, HL has been linked to sex, education, employment, and disease etiology in other countries, but data are scarce in Latin America. This study aimed to identify factors associated with HL in patients with liver cirrhosis in Cartagena, Colombia.

Patients and Methods: We conducted a cross-sectional, analytical study between September and December 2024. Adults with a confirmed diagnosis of cirrhosis completed the validated Spanish version of the Short Assessment of Health Literacy (SAHL-S). Scores below 14 indicated inadequate HL. A separate, validated questionnaire assessed disease-specific knowledge across four domains: diagnosis, signs/symptoms, treatment, and medication.

Results: A total of 93 patients were analyzed (61.2% female; mean age: 63.9 $\pm$ 11.7 years). MASLD and cryptogenic cirrhosis were the

most common etiologies (30% each), and 80% were Child-Pugh A. Adequate HL was found in 79.6% (mean SAHL-S score: 15.3). Knowledge was highest for treatment (77%) and lowest for signs/symptoms (65%).

Multivariable analysis identified higher education (OR 1.81), number of dependents (OR 2.03), and employment (OR 2.2) as positive predictors of HL. Older age (OR 0.95) and hypertension (OR 0.32) were negatively associated.

Conclusions: One in five cirrhotic patients had suboptimal HL, especially regarding symptom recognition. Sociodemographic and clinical factors should guide patient-centered interventions.

Conflict of interest: None

Table

Variable				n = 93
Female sex				61.2%
Mean age (SD), years				63.9 (11.7)
In a relationship				74.2%
Completed secondary education				35.5%
Urban residence				86%
Unemployed/retired/pensioned				60%
MASLD etiology				30%
Cryptogenic etiology				30%
Child-Pugh A				80%
Mean SAHL-S score				15.33
Adequate health literacy				79.6%
Basal Characteristics				

Factor	Odds Ratio (OR)	95% Confidence Interval (CI)	p-value
Education level	1,81	1.24 – 2.61	<0.001
Number of dependents	2,03	1.23 – 3.33	0.01
Employment status (employed)	2,2	1.09 – 4.51	0.03
Age	0,95	0.90 – 0.99	0.02
History of hypertension	0,32	0.12 – 0.85	0.02

Multivariate Analysis of Factors Associated With Health Literacy in Cirrhotic Patients

<https://doi.org/10.1016/j.aohep.2025.101953>

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MELD 3.0 PERFORMANCE: EXTERNAL VALIDATION IN A LATIN AMERICAN TRANSPLANT LIVER COHORT

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Introduction and Objectives: The MELD 3.0 score has demonstrated superior discriminatory performance for predicting 90-day waitlist mortality among liver transplant (LT) candidates in the US. This study aimed to validate the MELD 3.0 in a Latin American cohort.

Materials and Methods: Retrospective cohort study including adults LT candidates listed between 2016-2023 across five Latin American countries. Baseline data were registered at listing. Cox regression model was performed, with 90-day mortality as the primary outcome and LT as censored observation. Discriminative performance was assessed using Harrell’s c-index for MELD, MELD-Na and MELD 3.0. Net Reclassification Index (NRI) was also calculated.

Results: We included 1,013 patients: mean age 51 years (±11.8); 41.4% females, 25.8% obese, 58.1% ascites and 38.3% had encephalopathy were present in 58.1% and 38.3% of cases, respectively. Median MELD score was 16.9 (IQR 13.3–21.1), MELD-Na 18.3 (IQR 14.6–24), and MELD 3.0 19.5 (IQR 15.1–24.8). At 90 days, 26.3% underwent LT and 66.8% remained on the waitlist. The mortality incidence was 29.4 deaths per 1,000 patient-months, with a cumulative mortality of 8.3% (95% CI 6.6–10.4%) at 3 months. Hazard ratios for 90-day mortality were: MELD 1.15 (95% CI 1.12-1.19), MELD-Na 1.16 (95% CI 1.13-1.20), and MELD 3.0 1.15 (95% CI 1.12-1.19). Harrell’s c-index showed no significant differences (Table 1).NRI showed no significant improvement in risk reclassification using MELD 3.0.

Conclusions: In a region showing high waitlist mortality, MELD 3.0 did not demonstrate superior predictive performance over MELD or MELD-Na. These findings highlight the need for regional validation of predictive models before implementation in transplant prioritization policies.

Conflict of interest: None

Table 1: Discriminative Performance of MELD-Based Scores for Predicting 90-Day Waitlist Mortality

Model	Harrell’s C-index	95% Confidence Interval	p vs MELD	p vs MELD-Na
MELD	0.809	0.76 – 0.86	—	—
MELD-Na	0.821	0.77– 0.86	0.41	—
MELD 3.0	0.822	0.78 – 0.87	0.27	0.88
MELD 3.0 (no Alb)	0.822	0.78– 0.87	0.25	0.81

Note: All models evaluated at the time of listing. No statistically significant difference in discrimination was observed between scores.

<https://doi.org/10.1016/j.aohep.2025.101954>

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HEPATITIS C SCREENING AND GENDER DISPARITIES IN POSITIVITY RATES IN ARGENTINA

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Introduction and Objectives: Hepatitis C virus (HCV) infection is a major public health issue in Argentina. Despite effective antiviral therapies, many cases remain undiagnosed. Gender-based differences in healthcare access may influence screening practices and positivity rates.

To estimate overall HCV seropositivity, assess differences in testing and positivity rates by gender, and evaluate the association between HCV infection and mortality.