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FIBRATES SEEM TO BE EQUALLY EFFECTIVE AS SECOND-LINE THERAPY IN PRIMARY BILIARY CHOLANGITIS, WITH BIOCHEMICAL RESPONSE PLATEAUING AT 6 MONTHS

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Introduction and Objectives: Approximately 40% of patients with primary biliary cholangitis (PBC) exhibit an incomplete biochemical response to ursodeoxycholic acid (UDCA) and require second-line therapy. Fibrates are widely available in Latin America and commonly used off-label in this setting. We aimed to evaluate clinical and biochemical outcomes in PBC patients with incomplete UDCA response treated with different fibrates.

Materials and Methods: This ongoing, retrospective, multicenter cohort study (ALLATIN), sponsored by ALEH, includes PBC patients from several Latin American countries. For this analysis, only patients with incomplete response (based on biochemical criteria or physician judgment), who received fibrates, were included.

Results: Among 1,204 patients, 342 received fibrates; 263 (76.7%) were treated for incomplete UDCA response (93.2% female; mean age: 50 ± 11 years; 76.5% AMA-positive; 19.6% with cirrhosis). Bezafibrate, fenofibrate, and ciprofibrate were used in 72.2%, 7.2%, and 17.9% of cases. Median ALP before fibrates was 1.9xULN (IQR 1.4-3.0); median time from UDCA start to fibrate use was 30 months (IQR 13-69). At 6 months (n = 153), ALP normalization occurred in 42.5%, while 67.3% and 50.3% met Toronto and POISE criteria, respectively; 30.9% achieved deep response (normal ALP and bilirubin <0.6×ULN). At 12 months (n=150), rates remained stable. No differences were observed across fibrate types (p>0.4). Liver transplantation or death occurred in 24 patients (9.1%) over 87 months (IQR 44-135), associated with cirrhosis at diagnosis (OR 9.9; 95%CI 3.3-29.9; p<0.001) and response at 6 months by Toronto criteria (OR 0.31; 95%CI 0.1-0.9; p=0.035). Discontinuation occurred in 13.7%; adverse events included renal injury (n=1), myalgia (n=4), liver injury (n=4), and abdominal pain (n=4).

Conclusions: Fibrates showed high efficacy regardless of agent used. Biochemical response plateaued by 6 months and predicted long-term outcomes. These findings support early assessment and a pragmatic approach to second-line therapy in PBC, independent of fibrate type.

Conflict of interest: Yes, Gilead and ALEH

https://doi.org/10.1016/j.aohep.2025.102014

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FUELING THE FIRE: INFECTIONS TRIGGER AND MALNUTRITION DRIVES SEVERE ACLF IN CIRRHOSIS

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Introduction and Objectives: Cirrhosis-associated immune dysfunction (CAID) increases the risk of infections, which are the most common trigger of acute-on-chronic liver failure (ACLF), a syndrome with high short-term mortality. Malnutrition may further impair immune function and affect the course of ACLF. This study aimed to elucidate the interplay between nutritional status, cirrhosis etiology, infection type, their combined impact on ACLF severity and clinical outcomes.

Materials and Methods: A retrospective analysis of 19 cirrhotic patients with ACLF treated between February 2023 and January 2024 at a tertiary centre was conducted. Data included infection type, nutritional status, cirrhosis etiology, ACLF grade, and in-hospital mortality.

Results: A total of 19 patients (6 females [32%],13 males [68%]), median age of 68 years (range 40–80) were included. Infections were the trigger for ACLF in 13 patients (68%), most commonly respiratory. Fungal or polymicrobial infections were identified in 6 patients

(32%), including Klebsiella pneumoniae, Candida spp., Chlamydia sp., and Mycoplasma pneumoniae. Among patients with ACLF grade 3, 4 of 6 (67%) had fungal or polymicrobial infections. Malnutrition was observed in 9 patients (47%), including 3 of 6 (50%) with ACLF grade ≥2. It was more common in alcoholic cirrhosis (7 of 12; 58%) than in non-alcoholic cases (2 of 7; 29%). In-hospital mortality occurred in 6 patients (32%); 3 deaths (50%) were infection-related and 4 (67%) involved malnourished patients.

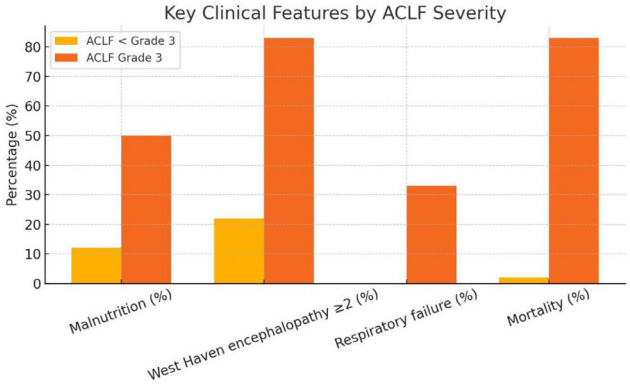
Conclusions: Malnutrition, alcohol-related cirrhosis, fungal or polymicrobial infections were associated with more severe ACLF and poorer outcomes. Early recognition of these risk factors may improve prognostication and guide therapy.

Conflict of interest: None

Comparison of Clinical Characteristics by ACLF Grade

Variable	ACLF grade < 3 (n=13)	ACLF grade 3 (n=6)
Mean age (years)	64.2 ± 11.7	61.7 ± 16.5
Mean bilirubin (µmol/l)	106.2 ± 145.4	313.0 ± 220.0
Mean creatinine (µmol/l)	127.6 ± 99.2	303.3 ± 75.4
Mean INR	13.1 ± 31.8	3.1 ± 1.4
Malnutrition (%)	12%	50%
West Haven encephalopathy ≥2 (%)	22%	83%
Respiratory failure (%)	0%	33%
Mortality (%)	2%	83%

Key clinical features by ACLF severity



https://doi.org/10.1016/j.aohep.2025.102015

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SPLEEN STIFFNESS PREDICTS ESOPHAGEAL VARICES IN LATIN AMERICAN CIRRHOTIC PATIENTS: CLINICAL AND ENDOSCOPIC CORRELATIONS

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Introduction and Objectives: Portal hypertension (PHT) is a major driver of complications and mortality in cirrhosis. Spleen stiffness measurement (SSM) via FibroScan® has emerged as a non-invasive marker of clinically significant PHT (CSPH) and esophageal varices (EV), yet evidence in Latin America is limited. This study aimed to correlate SSM with cirrhosis severity and markers of CSPH, compare its values with those of healthy controls, and determine an optimal cutoff for EV detection.

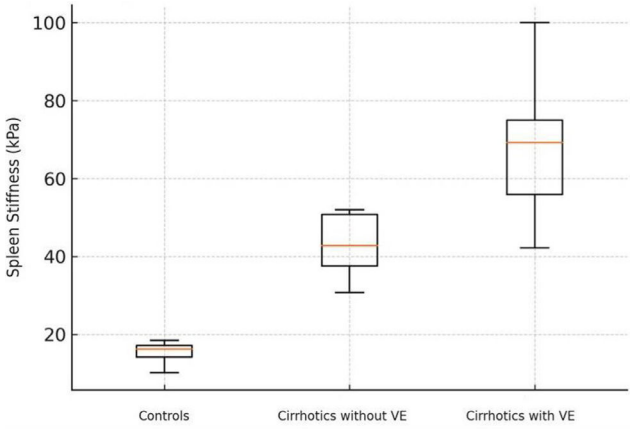
Materials and Methods: Cross-sectional study including 40 cirrhotic patients (β-blocker naïve) and 10 healthy controls. SSM (kPa) was measured with FibroScan® Expert 630. Variables included Child−Pugh class, MELD-Na, D'Amico stage (≥4 = decompensation), platelet count, Doppler ultrasound, and endoscopic confirmation of EV. Statistical analysis included non-parametric tests, ROC curves, Youden's index, and multivariable logistic regression (SSM, platelets, portal vein diameter, Child−Pugh).

Results: Mean age was 56.8 years; 60% male; BMI 28.8 kg/m^2; 40% obese. Median SSM was higher in cirrhotics (64.5 kPa) than in controls (16.0 kPa; $p < 0.001$). Among cirrhotics, higher SSM correlated with Child−Pugh C ($p = 0.004$), MELD-Na ≥ 22 ($p = 0.018$), decompensation ($p = 0.030$), and thrombocytopenia ($p = 0.021$). EV were present in 22 patients (55%), with SSM 67.3 vs 46.0 kPa ($p = 0.004$). AUC was 0.81; optimal cutoff 55 kPa. Only SSM remained independently associated with EV (OR 1.14 per kPa; AUC 0.91).

Conclusions: In this Latin American cohort, SSM ≥ 55 kPa was the most accurate non-invasive predictor of EV and may guide endoscopic screening in clinical practice.

Conflict of interest: None

Comparison of Spleen stiffness measurement (kPa) between controls, cirrhotics without esophageal varices (VE), and cirrhotics with VE.



https://doi.org/10.1016/j.aohep.2025.102016

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VISCERAL FAT AS A KEY DRIVER OF LIVER FIBROSIS IN MASLD: A DXA-BASED ANALYSIS

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Introduction and Objectives: Adiposity is associated with an increased risk of developing metabolic dysfunction-associated steatotic liver disease (MASLD).

Verify the association between liver fibrosis and visceral adiposity in MASLD by Dual-energy X-ray absorptiometry (DXA) method.

Materials and Methods: In a cross-sectional study, assessment of MASLD and significant fibrosis (F≥2) were performed by