to HAV and are therefore assumed to be immune, making vaccination seem unnecessary.

To determine the frequency of IgG antibodies against HAV in patients undergoing medical evaluation for altered liver function tests.

Materials and Methods: A cross-sectional descriptive study was conducted in the gastroenterology outpatient clinic of a private institution between January 2023 and January 2025. Adult patients presenting with abnormal liver enzyme tests were included. Foreign nationals and minors were excluded. Informed consent was obtained, and participants were asked about a history of HAV infection and vaccination.

Results: A total of 250 patients were included, with a mean age of 56.4 ± 15.5 years (range: 18–90); 51.2% (n = 128) were male. IgG anti-HAV seropositivity was found in 74.4% of participants. Among those who reported having had hepatitis A, 74% were IgG positive. Additionally, 88.4% of patients did not know their vaccination status.

Conclusions: Although Peru is considered an endemic area for HAV, only 74.4% of adults in our serie showed serologic evidence of immunity. Self-reported infection or vaccination history was not a reliable predictor of HAV immunity.

Conflict of interest: None

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PRESENTATION AND FOLLOW-UP OF POST-TRANSPLANT LYMPHOPROLIFERATIVE DISORDER THROUGH 2005-2022 AT A LIVER TRANSPLANT UNIT IN BOGOTA, COLOMBIA

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Introduction and Objectives: Post- transplant lymphoproliferative disorders (PTLD) are a group of neoplasms developed after transplantation, associated with increased mortality. The incidence of PTLD in liver transplant is 1-5.5%. Risk factors include immunosuppression, Epstein Barr Virus (EBV) mismatch and acute rejection. Clinical presentation is diverse. Treatment options include reduction of immunosuppression (RIS), rituximab and chemotherapy. The objective is to evaluate the incidence and clinical-pathological characteristics of patients with PTLD in our center.

Materials and Methods: Retrospective analysis of orthotopic liver transplant (OLT) patients over 18 years old in La Cardio from January 2005 to December 2022 was collected to identify PTLD patients. After identifying PTLD patients, demographic details, indication for liver transplant, induction and maintenance immunosuppressive regimen, EBV status, acute rejection episodes, histopathological classification of PTLD, chemotherapy used, and outcome were analysed in each case.

Results: Of a total of 617 OLT patients 4 developed PTLD representing a prevalence of 0.6% during a 17-year period of follow-up. Of the patients, 3 (75%) were female. Chronic hepatitis C, chronic hepatitis B, alcoholic hepatitis and autoimmune hepatitis was the etiology of cirrhosis in each of the patients. Median age of the cohort was 44 years. Median time of presentation for PTLD was 52,7 months since liver transplant. More detailed information is in table 1.

Conclusions: This study showed a low prevalence of PTLD among OLT recipients. Most of the patients responded well to RIS and chemotherapy. Further and multi-center studies are needed to provide a better understanding of PTLD in our population.

Conflict of interest: None

Patient	VEB mismatch	Induction	Maintenance	Rejection	Histopathological classification of PTLD	Managment	Outcome
A	No	Bolus of Metil prednisolone	Ciclosporine-Mycophenolate and steroid	Acute moderate rejection at 18 months of transplantation	Monomorphic diffuse large B-cell lymphoma type, phenotype compatible with germinal center subtype	R-CHOP for 4 cycles followed by Rituximab monotherapy and reduction immunosuppression	Complete response with no relapse
B	No	Bolus of Metil prednisolone	Ciclosporine-Mycophenolate and steroid	Never	Monomorphic diffuse large B-cell lymphoma type, phenotype compatible with germinal center subtype	Rituximab monotherapy for 3 cycles followed by R-CHOP for 3 cycles	Progression and death
C	No	Bolus of Metil prednisolone	Tacrolimus-Mycophenolate and steroids	Acute moderate rejection at 69 months of transplantation	Burkitt-type B-cell lymphoma stage IVA with nodal involvement (left cervical adenopathy) and extranodal involvement (Left tonsil	Da-EPOCH-R for 5 cycles followed by 3 cycles of Rituximab monotherapy	Complete response
D	No	Bolus of Metil prednisolone	Ciclosporine-Mycophenolate and steroid	Never	Non-Hodgkin Lymphoma	R-CHOP for 8 cycles followed by 3 cycles of Rituximab monotherapy	Complete response

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