Cytomegalovirus IgM 3 (6%), with one CMV case in the DILI/HILI group. Thirteen cases (26%) had undefined or non-hepatic causes. Two groups were stratified: Group 1 with DILI/HILI (17) and Group 2 without DILI/HILI (33). Median values were calculated for ALT, AST, ALP, GGT, and bilirubin total. Group 1: AST 257 U/L, ALT 313 U/L, GGT 696 U/L, ALP 234 U/L, BT 7.6 mg/dL. Group 2: AST 162 U/L, ALT 109 U/L, GGT 216 U/L, ALP 172 U/L, TB 4.9 mg/dL. AST, ALT, and GGT were higher in the DILI/HILI group. No statistical difference in ALP and BT (p=0.5120; p=0.8057).

Conclusions: DILI/HILI cases showed a more prominent biochemical profile, suggesting more severe liver injury. Careful investigation of drug and herbal use is essential in the evaluation of acute hepatitis.

Conflict of interest: None

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#106

TRANSPLANT-FREE SURVIVAL AMONG PATIENTS WITH HEPATOCELLULAR CARCINOMA MANAGED AT A TERTIARY REFERRAL HOSPITAL IN PERU

Mariella Rosalina Huaman Rivera[1], Diego Francisco Pinto Ruiz[1], Estefania Liza Baca[2], Zuly Placido Damian[2], Javier Diaz Ferrer[2]

[1] *Sociedad Científica de San Fernando. Facultad de Medicina. Universidad Nacional Mayor de San Marcos, Peru.*
[2] *Servicio de Hígado. Hospital Nacional Edgardo Rebagliati Martins, Peru.*

Introduction and Objectives: Peru has one of the highest liver cancer rates in South America, yet limited access to transplantation makes evaluating prognosis through alternative treatments essential. We aimed to determine transplant-free survival in patients with hepatocellular carcinoma (HCC) treated at "Hospital Nacional Edgardo Rebagliati Martins" (HNERM), Lima, Peru.

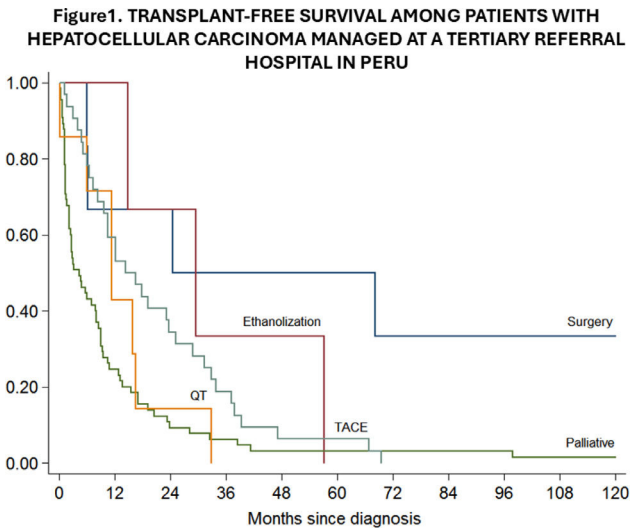
Materials and Methods: Retrospective cohort study using data from patients hospitalized in the hepatology unit of HNERM (2012-2014). We included adults diagnosed with HCC by CT, MRI, or biopsy; those with prior liver transplants or lost to follow-up were excluded. We reviewed clinical records and the national death registry over 120 months. Transplant-free survival was estimated using Kaplan–Meier, and survival differences by cirrhosis, BCLC-stage, and treatment were assessed using the Mantel–Haenszel method (α=0.05).

Results: A total of 112 patients with HCC were included (median age 68 [IQR:60-75years]; 51.8% female). The leading etiology of HCC was viral (HBV 31.3%, HCV 15.2%, co-infection 4.5%), followed by NAFLD. 87.5% had cirrhosis, Child-Pugh B. Participants without cirrhosis were significantly younger (p<0.01). Overall, 57.1% received palliative care, followed by TACE (28.6%), chemotherapy (6.3%), surgery (5.4%), and ethanol injection (2.7%). Transplant-free survival rates were 59.8% at 6 months and 1.8% at 120 months. Median survival was 8.0 months with cirrhosis and 11.3 without, with no significant difference. Surgical treatment showed better survival outcomes (p<0.01) (figure1). Among patients with cirrhosis, 60-month survival significantly varied by BCLC stage, favoring earlier stages (p<0.01)

Conclusions: Early diagnosis regardless of cirrhosis status and broader treatment availability are crucial to improve HCC survival in Peru.

Conflict of interest: None

Transplant-free survival among patients with hepatocellular carcinoma managed at a tertiary referral hospital in Peru



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#107

PREDICTIVE FACTORS OF RESPONSE TO URSODEOXYCHOLIC ACID TREATMENT IN MEXICAN PATIENTS WITH PRIMARY BILIARY CHOLANGITIS

Fátima Higuera de la Tijera[1], Graciela Elia Castro Narro[2], Ana Cano Contreras[3], José Luis Pérez Hernández[1], Jorge Emilio Lira Vera[4], José Antonio Velarde Ruiz Velasco[5]

[1] *Hospital General de México "Dr. Eduardo Liceaga".*
[2] *Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, México.*
[3] *Instituto de Investigaciones Médico Biológicas de la Universidad Veracruzana, México.*
[4] *Hospital Ángeles. San Luis Potosí, México.*
[5] *Hospital Civil de Guadalajara Fray Antonio Alcalde. Guadalajara. México*

Introduction and Objectives: Non-responders (NR) to ursodeoxycholic acid (UDCA) are at risk of disease progression. The aim was to identify risk factors associated with treatment response (improvement or failure) to UDCA in primary biliary cholangitis (PBC).

Materials and Methods: A case-control study nested within a cohort. Treatment response with UDCA was evaluated with the Barcelona criteria. We compared variables between responders (R) and NR. To evaluate risk factors we performed uni and multivariate logistic regression analyses. A P-value < 0.01 was considered significant.

Results: 329 patients with PBC from 5 tertiary-care centers in Mexico, 95.4% women, mean age 52.5±10.9 years. All received UDCA (13-15 mg/kg/day) and reported treatment adherence; 159 (48.3%) NR. In a sample of 119 patients with complete data for analysis, 98.3% women, mean age 49.9±11.4 years, 49 (41.2%) NR. Univariate analysis: albumin 3.5 range=2.0-4.8 vs. 4.0 range=2.6-4.8 mg/dL; and platelet count 118 range=52-518 vs. 200 78-436 cell/10^9/L were lower in

NR (P<0.0001). Bilirubin 1.9 range=1.0-6.4 vs. 1.6 range=1.0-3.0 mg/dL (P<0.0001), and alkaline phosphatase 666 range=143-1445 vs. 480 range=170-1556 IU/L (P=0.01) were higher in NR. NR had a higher proportion of advanced fibrosis/cirrhosis 83.7% vs. 25.7%; P<0.0001; OR=14.8, 95%CI=5.8-37.4; obesity 81.6% vs.31.4%; P<0.0001; OR=9.7, 95%CI=4.0-23.4; autoimmune hepatitis overlap (AIHo) 42.9% vs. 7.1%; P<0.0001; OR=9.8, 95%CI=3.3-28.5; and longer disease course: 5-10 years 44.9% vs. 38.6%; P=0.004; OR=4.3, 95%CI=1.6-11.5; and >10 years 40.8% vs. 8.6%; P<0.0001; OR=17.6, 95%CI=5.2-59.6. The statins add-on enhanced the response to UDCA 60% vs. 16.3%; P<0.0001; OR=0.1, 95%CI=0.05-0.3. Fibrates use, age, AST, ALT, GGT, cholesterol, and INR were not different between groups. The results obtained in the multivariate analysis are shown in Table 1.

Conclusions: Statins improved response to UDCA. AIHo, advanced fibrosis/cirrhosis, bilirubin >2.0 mg/dL, and obesity were factors related to NR.

Conflict of interest: None

Comparison of Clinical and Biochemical Characteristics Between Responders and Non-Responders to UDCA Treatment in Patients with PBC According to Barcelona Criteria: Univariate Analysis

Clinical and Biochemical Characteristics	Responders (n = 70)	Non-Responders (n = 49)	P-value	OR (95% CI)
Age, years	50.5 ± 11.8	48.9 ± 10.9	0.46	NA
Alkaline phosphatase, U/L	480 (170–1556)	666 (143–1445)	0.01	NA
Platelets, x 10?/L	200 (78–436)	118 (52–518)	< 0.0001	NA
Total bilirubin, mg/dL	1.6 (1.0–3.0)	1.9 (1.0–6.4)	< 0.0001	NA
ALT, U/L	75 (21–185)	102 (19–456)	0.07	NA
AST, U/L	77 (23–204)	98 (18–333)	0.12	NA
GGT, U/L	354 (86–1349)	444 (99–1238)	0.05	NA
Cholesterol, mg/dL	215 (85–779)	198 (85–409)	0.29	NA
Albumin, g/dL	4.0 (2.6–4.8)	3.5 (2.0–4.8)	< 0.0001	NA
INR	1.0 (0.7–1.5)	1.0 (0.8–1.5)	0.50	NA
Fibrosis F3 or F4, n (%)	18 (25.7%)	41 (83.7%)	< 0.0001	14.8 (5.8–37.4)
Obesity, n (%)	22 (31.4%)	40 (81.6%)	< 0.0001	9.7 (4.0–23.4)
AIH overlap, n (%)	5 (7.1%)	21 (42.9%)	< 0.0001	9.8 (3.3–28.5)
Dyslipidemia, n (%)	44 (62.9%)	11 (22.4%)	< 0.0001	0.2 (0.08–0.4)
Statin use, n (%)	42 (60%)	8 (16.3%)	< 0.0001	0.1 (0.05–0.3)
Fibrate use, n (%)	33 (47.1%)	23 (46.9%)	0.98	1.0 (0.5–2.1)
PBC duration < 5 years	37 (52.8%)	7 (14.3%)	Ref	Ref
PBC duration 5 to 10 years	27 (38.6%)	22 (44.9%)	0.004	4.3 (1.6–11.5)
PBC duration > 10 years	6 (8.6%)	20 (40.8%)	< 0.0001	17.6 (5.2–59.6)
Total bilirubin > 2.0 mg/dL, n (%)	13 (18.6%)	24 (48.9%)	< 0.0001	4.2 (1.8–9.6)

Multivariate Analysis of Factors Associated with Response or Failure to UDCA Treatment in PBC Patients (Barcelona Criteria)

Variable	OR (95% CI)	P-value
Total bilirubin > 2.0 mg/dL	4.4 (1.1 – 17.0)	0.03
Fibrosis F3 or F4	7.1 (1.9 – 26.6)	0.004
Obesity	4.9 (1.4 – 17.9)	0.015
AIH overlap	20.8 (3.1 – 137.6)	0.002
Statin use *	0.08 (0.02 – 0.4)	0.002
PBC duration 5 to 10 years	1.2 (0.3 – 5.4)	0.78
PBC duration > 10 years	6.1 (1.0 – 38.3)	0.05

Abbreviations: AIH = Autoimmune Hepatitis; CI = Confidence Interval; F3 = Advanced Fibrosis; F4 = Cirrhosis; OR = Odds Ratio; PBC = Primary Biliary Cholangitis; UDCA = Ursodeoxycholic Acid.

* = **Protective factor.**

Multivariate analysis: Binary logistic regression.

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FROM POLICY TO PRACTICE: HEPATITIS C CARE INDICATORS IN URUGUAY BEFORE AND AFTER THE INTRODUCTION OF PUBLIC HEALTH STRATEGIES

Victoria Mainardi[1], Susana Cabrera[2], Luciana Noble[3], Daniela Olivari[4], Solange Gerona[4], Sebastian Marciano[5], Huaiyang Zhong[6], Julio Medina[7]

[1] *Program for STIs, Viral Hepatitis and HIV. Ministry of Public Health. Uruguay. National Liver Transplant Program. Central Hospital of the Armed Forces. Montevideo. Uruguay.*
[2] *Program for STIs, Viral Hepatitis and HIV. Ministry of Public Health. Uruguay. Academic Unit of Infectious Diseases. School of Medicine. Universidad de la República. Uruguay.*
[3] *Program for STIs, Viral Hepatitis and HIV. Ministry of Public Health. Uruguay.*
[4] *National Liver Transplant Program. Central Hospital of the Armed Forces. Montevideo. Uruguay.*
[5] *Hospital Italiano University. Buenos Aires. Argentina.*
[6] *Grado Department of Industrial and Systems Engineering. Virginia Tech, USA.*
[7] *National Liver Transplant Program. Central Hospital of the Armed Forces. Montevideo. Uruguay. Academic Unit of Infectious Diseases. School of Medicine. Universidad de la República. Uruguay.*

Introduction and Objectives: Uruguay has implemented measures since 2022 to strengthen its hepatitis C response, aligned with WHO's 2030 elimination targets. These include national guidelines and awareness campaigns. In July 2024, two key policies were introduced: the inclusion of HCV RNA testing in the national health plan and a one-time anti-HCV screening during mandatory health exams for work and physical activity, initially targeting individuals aged 56–64.

We aimed to assess differences in the national hepatitis C cascade of care before and after the implementation of these public policies.

Materials and Methods: Data were collected through structured surveys sent by the Ministry of Health to all 44 national healthcare providers. Cascade indicators were analyzed for 2022, 2023 and 2024, including anti-HCV testing, seropositivity, HCV RNA testing, RNA positivity, and treatment initiation. All indicators were normalized per 100,000 users covered by respondents.

Results: In 2024, 29 healthcare providers responded (covering 90% of health system users). In 2022–2023, 22 providers reported laboratory indicators (35% coverage), while 25 reported treatment indicators (73%).

Anti-HCV testing rose from 2,883 in 2022 to 5,548 per 100,000 users in 2024. HCV RNA testing increased from 6.1 to 20.4, and treatment initiation from 2.6 to 4.9 per 100,000 users. Seropositivity remained stable (0.7%). Among anti-HCV–positive individuals, HCV RNA testing uptake increased from 37% in 2022 to 54% in 2024.

Conclusions: Improvements observed in the cascade of care align with the implementation of targeted hepatitis C policies, highlighting their potential role in supporting national elimination efforts.

Conflict of interest: None