

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 ⁷ /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

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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.

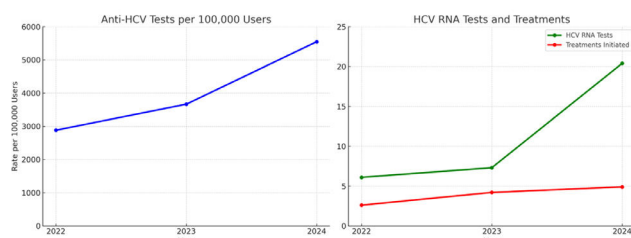
Results: In 2024, 29 healthcare providers responded (covering 90% of health system users). In 2022–2023, 22 providers reported laboratory indicators (35% coverage), while 25 reported treatment indicators (73%).

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

Hepatitis C Cascade Indicators per 100,000 Users (Uruguay, 2022–2024) – Adjusted



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CHARACTERIZATION OF PATIENTS CO-INFECTED WITH HEPATITIS C AND HIV IN THE NORTH REGION OF BRAZ

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Introduction and Objectives: Patients co-infected with Human Immunodeficiency Virus (HIV) and hepatitis C virus (HCV) are at higher risk of unfavorable outcomes, such as accelerated development of liver fibrosis and cirrhosis, as well as increased morbidity and mortality.

To describe the profile of patients co-infected with hepatitis C and HIV in the North region of Brazil between 2013 and 2023.

Materials and Methods: A descriptive, cross-sectional study using data from the Notifiable Diseases Information System (Sinan) for the period from 2013 to 2023. The variables analyzed were sex, race, and education level. Descriptive statistical analysis was performed to characterize the profile of the cases.

Results: A total of 420 cases of co-infection with hepatitis C and HIV were identified. The majority were male (69.0%) and self-declared as "pardo" (brown/mixed-race) (81.4%). Regarding education level, 26.2% of the records were unknown; among the available data, those with complete high school education (19.0%) and 5 to 8 incomplete years of study (18.1%) stood out. In terms of geographical distribution, Amazonas had the highest proportion of cases (38.8%), followed by Pará (29.5%) and Rondônia (16.7%).

Conclusions: The data indicate a predominant profile of co-infection among men, "pardo" individuals, and those with low education levels, with a concentration in the state of Amazonas. These findings reinforce the need for specific prevention, diagnosis, and care strategies aimed at the most vulnerable populations in the North region.

Conflict of interest: None

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DATA OMISSION IN COMPULSORY NOTIFICATION FORMS RELATED TO HEPATITIS A, B AND C AND HIV CO-INFECTION

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Introduction and Objectives: Co-infection with Human Immunodeficiency Virus (HIV) and hepatitis C virus (HCV) represents a significant public health challenge in Brazil, as it is associated with worsening clinical outcomes, such as accelerated progression of liver disease and increased morbidity and mortality.

To describe the rate of incomplete reporting related to HCV and HIV co-infection among individuals notified between 2013 and 2023 in the North region of Brazil.

Materials and Methods: This is a descriptive, cross-sectional study conducted using data from the Notifiable Diseases Information System (Sinan) database for the period from 2013 to 2023. The variables used were viral hepatitis classification and co-infection with HIV. Subsequently, a descriptive analysis was performed to identify omissions in the HIV co-infection variable in viral hepatitis notifications.

Results: A high number (18.6%) of data omissions was observed regarding HIV and viral hepatitis co-infection. Among the types, the highest omission rate was observed in hepatitis A notifications (21.7%), followed by hepatitis C (20.3%) and hepatitis B (17%). Among the states, Roraima showed the highest percentage of omission of information on HIV diagnosis (23.2%).

Conclusions: The data reveal a significant percentage of omissions regarding the investigation of HIV co-infection in viral hepatitis notifications, especially for hepatitis A (21.7%), C (20.3%), and B (17%). This weakness in the completeness of information compromises epidemiological surveillance and health action planning.

Conflict of interest: None

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IMPACT OF HEPATITIS A VACCINATION IN PRIORITY ADULT GROUPS AS AN OUTBREAK CONTAINMENT STRATEGY IN BRAZIL

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Introduction and Objectives: Viral hepatitis A (HAV) is an infection primarily transmitted via the fecal-oral route. In 2016, the World Health Organization observed an increase in HAV cases in low-endemicity countries, associated with oral-anal sexual practices.

To evaluate the outcome of hepatitis A vaccination in adults from priority groups as a strategy for containing the hepatitis A outbreak.