showed intense labeling in BDL and reduction with EX and MLT ($p<0.001$).

Conclusions: The EX and MLT showed protective effects in this experimental model, improving biochemical, histological and molecular parameters in the liver-intestinal axis.

Conflict of interest: None

Histology of the intestine by HE

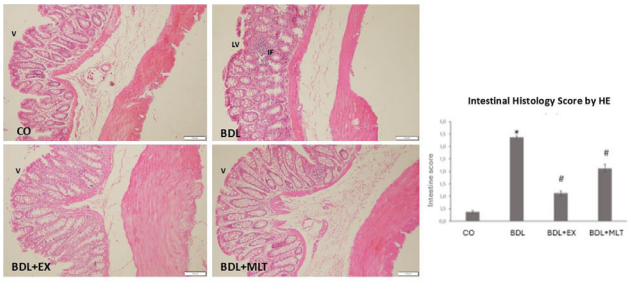

Figure 1: Intestinal epithelial histology (HE): (100x). Legend: villi (V), villus loss (LV), inflammatory infiltrate (IF). Data are expressed as mean ± standard error. * = p<0.001; # = p<0.001. CO: control; BDL: bile duct ligation; BDL+EX: bile duct ligation + exercise; BDL+MLT: bile duct ligation + melatonin.

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#171

ASSESSMENT OF LIPID PROFILE AND ESTIMATED CARDIOVASCULAR RISK IN PATIENTS WITH PRIMARY BILIARY CHOLANGITIS

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Introduction and Objectives: Primary biliary cholangitis (PBC) is characterized by a distinctive lipid profile, partly influenced by elevated lipoprotein-X, not routinely measured in clinical practice. In Mexico, genetic predisposition to metabolic disorders increase cardiovascular risk. This study aimed to determine the lipid profile in patients with PBC and compare it with individuals without chronic liver disease (CLD).

Materials and Methods: A retrospective, observational, analytical case-control study was conducted in 2025, including 50 female patients aged 40–60 years with compensated PBC treated at a tertiary care hospital. They were compared with 50 age- and sex-matched controls without CLD. Variables included lipid profile, glycemic control, and 10-year cardiovascular risk estimated using Framingham and ASCVD scores. Statistical analysis used central tendency, dispersion, and Student's t-test ($p < 0.05$).

Results: PBC patients showed higher mean total cholesterol (166 ± 69.8 vs. 146 ± 50.2 mg/dL), HDL (52.98 ± 26.78 vs. 45.52 ± 25.90 mg/dL), and LDL (91.52 ± 53.72 vs. 86.02 ± 39.22 mg/dL), though differences were not statistically significant. Triglycerides (107.76 ± 46.0 vs. 150.3 ± 67.3 mg/dL, $p < 0.01$) and HbA1c (5.42 ± 0.91% vs. 6.09 ± 1.02%, $p < 0.01$) were significantly lower in PBC. However, ASCVD risk was significantly higher in PBC (2.2 ± 1.3% vs. 1.59 ± 0.92%, $p = 0.01$), while Framingham risk was similar.

Conclusions: Despite a more favorable metabolic profile, PBC patients showed higher ASCVD-estimated cardiovascular risk, suggesting current risk tools may underestimate disease-specific factors.

Conflict of interest: None

Variable	PBC (n=50)	Control (n=50)	p-value
Total cholesterol (mg/dL)	166 ± 69.8	146 ± 50.2	0.07
HDL cholesterol (mg/dL)	52.98 ± 26.8	45.52 ± 25.9	0.15
LDL cholesterol (mg/dL)	91.52 ± 53.7	86.02 ± 39.2	0.59
Triglycerides (mg/dL)	107.76 ± 46.0	150.3 ± 67.3	< 0.01
Glycated hemoglobin (%)	5.42 ± 0.91	6.09 ± 1.02	< 0.01
10-year cardiovascular risk (Framingham score) (%)	4.16 ± 0.02	4.02 ± 2.70	0.81
10-year cardiovascular risk (ASCVD score) (%)	2.2 ± 1.3	1.59 ± 0.92	0.01

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#172

FRAILTY ASSESSMENT IN LIVER TRANSPLANT CANDIDATES AND ITS IMPACT ON DECISION-MAKING – A LATIN AMERICAN SURVEY

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Introduction and Objectives: Frailty in cirrhosis is associated with adverse outcomes both before and after liver transplantation (LT). Clinical guidelines recommend its diagnosis and management; however, no clear guidance exists regarding its applicability for transplant eligibility, deferral, prioritization, or futility.

To characterize current practices among physicians regarding frailty assessment in LT candidates, and to describe its usefulness in clinical decision-making.

Materials and Methods: Descriptive observational study. Data were collected via an online survey targeting physicians who evaluate cirrhotic patients as LT candidates in Latin America.

Results: A total of 92 responses were obtained, with 91.3% of participants being hepatologists or gastroenterologists. Country distribution was: Chile (23.1%), Argentina (22.0%), Peru (12.1%), Mexico (8.8%), Brazil (6.6%), Colombia (6.6%), and others (20.8%). Frailty is assessed by 93.5% of respondents, with the most commonly used methods being the Liver Frailty Index (45.4%), Karnofsky score (33.7%), 6-minute walk test (25.6%), and handgrip strength (25.6%). For 63.95% of participants, frailty assessment influences decisions to delay listing or exclude patients from LT. In 39.53% and 30.23%, it influences preoperative optimization and postoperative planning, respectively. Reported challenges include limited time and staffing (68.48%), lack of standardized tools (45.65%), and limited access to equipment (29.35%).

Conclusions: Most physicians are already assessing frailty using validated objective methods. Although standardized recommendations are lacking, frailty assessment influences decision-making in the context of LT.

Conflict of interest: None

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