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DEMOGRAPHIC, CLINICAL, AND BIOCHEMICAL CHARACTERISTICS IN PATIENTS WITH PRIMARY BILIARY CHOLANGITIS WITH AN UNFAVORABLE BIOCHEMICAL RESPONSE TO URSODEOXYCHOLIC ACID IN A TERTIARY CARE HOSPITAL

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**Introduction and Objectives:** Ursodeoxycholic acid (UDCA) is the standard treatment for primary biliary cholangitis (PBC), leading to improvement in liver biochemical parameters in most patients. However, up to one-third fail to achieve an adequate biochemical response, which has been associated with more rapid progression to cirrhosis and other complications. Identifying clinical and biochemical factors associated with an unfavorable response may help optimize therapeutic strategies and enable early risk stratification.

This study aimed to identify clinical, demographic, and biochemical characteristics associated with an inadequate biochemical response to UDCA in patients with PBC.

**Materials and Methods:** We conducted a retrospective, observational, analytical, case-control study with longitudinal follow-up in 73 patients with confirmed PBC treated with UDCA for at least 12 months at a tertiary care hospital (2022–2024). Biochemical response was evaluated using Paris II, Barcelona, and Globe criteria. Variables analyzed included age, sex, BMI, time since diagnosis, liver enzymes (ALP, AST, ALT), bilirubin, albumin, platelet count, liver fibrosis by elastography, autoantibody profiles (AMA, SP100, GP210), and metabolic comorbidities. Statistical analysis was performed using measures of central tendency and dispersion, as well as absolute and relative frequencies. Group comparisons were conducted using Student's t-test, with statistical significance set at  $p < 0.05$ .

**Results:** Among the 73 patients, 52% ( $n=38$ ) were classified as non-responders. Non-responders were older ( $55 \pm 9.2$  vs.  $51 \pm 8.5$  years;  $p=0.04$ ) and had significantly higher baseline bilirubin ( $2.3$  vs.  $0.9$  mg/dL;  $p<0.01$ ) and ALP ( $361$  vs.  $240$  U/L;  $p<0.01$ ). Fibrosis on elastography was more frequent in non-responders ( $47\%$  vs.  $21\%$ ;  $p=0.01$ ). Autoantibody positivity was also higher among non-responders ( $38\%$  vs.  $22\%$ ;  $p=0.05$ ).

**Conclusions:** These results highlight key markers of unfavorable UDCA response and support the need for personalized monitoring and consideration of alternative therapies in high-risk PBC patients.

**Conflict of interest:** None

| Clinical and Biochemical findings | Non-Responders (n= 38) | Responders (n= 35) | p-value |
|-----------------------------------|------------------------|--------------------|---------|
| Mean age (years)                  | 55 ± 9.2               | 51 ± 8.5           | 0.04    |
| Total bilirubin (mg/dL)           | 2.3                    | 0.9                | <0.01   |
| Alkaline phosphatase (U/L)        | 361                    | 240                | <0.01   |
| Hepatic fibrosis (elastography)   | n = 18 (47%)           | n = 7 (21%)        | 0.01    |
| Positive autoantibodies           | n = 14 (38%)           | n = 8 (22%)        | 0.05    |
| Female sex                        | 84%                    | 86%                | 0.78    |
| BMI (kg/m <sup>2</sup> )          | 26.7 ± 4.3             | 25.9 ± 3.8         | 0.43    |
| AST (U/L)                         | 56 ± 12                | 54 ± 11            | 0.50    |
| ALT (U/L)                         | 49 ± 10                | 46 ± 9             | 0.28    |

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LIPID PROFILE-RELATED MARKERS AS PREDICTORS OF 28- AND 90-DAY MORTALITY IN PATIENTS WITH ALCOHOL-RELATED DECOMPENSATED CIRRHOSIS (DC) AND ACUTE-ON-CHRONIC LIVER FAILURE (ACLF): FIRST STUDY IN PATIENTS FROM WESTERN MEXICO

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**Introduction and Objectives:** DC and ACLF represent critical stages of alcohol-related chronic liver disease. Infections substantially increase mortality; therefore, the search for prognostic markers is important to predict clinical outcomes. Lipid profile has been shown to be associated with immunomodulatory processes and liver dysfunction; however, their role has been little investigated in patients from western Mexico. The objective was to evaluate the lipid profile in patients with alcohol-related DC and ACLF, and its association with infections and mortality.

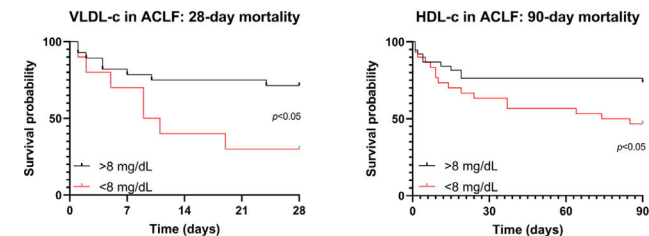
**Materials and Methods:** Analytical cross-sectional study. Serum samples from 91 patients (DC=30, ACLF=61) were analyzed, plus 33 healthy controls (HC). Lipid profile quantification was performed using automated methods. ROC curves and Kaplan-Meier analyses were made using GraphPad. Approval number: 00012. No conflicts of interest are reported.

**Results:** ACLF group showed a significant decrease in triglycerides, LDL-c, and VLDL-c compared to DC and HC. Importantly, LDL-c and VLDL-c were effective to discriminate DC from ACLF (AUROC=0.73 and 0.71). The significant decrease in HDL-c with infection, and 28- and 90-day mortality in both groups DC and ACLF groups showed an AUROC of 0.72 for infection vs. non-infection, plus 0.98 and 0.75 for 28- and 90-day mortality, respectively. In ACLF, VLDL-c <8 mg/dL was associated with a 25% survival rate at 28 days.

**Conclusions:** Triglyceride, LDL-c, and VLDL-c levels progressively decline with the severity of cirrhosis. LDL, VLDL, and potentially HDL cholesterol are emerging as practical biomarkers for discriminating infections and mortality in DC and ACLF. These findings demonstrate the impact of lipid profiles on the prognosis and stratification of these patients.

**Conflict of interest:** None

Kaplan-Meier mortality analysis on 28- and 90-day mortality in ACLF patients, according to the VLDL-c (left) and HDL-c (right) thresholds established by ROC curves.



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CLINICAL RESULTS IN PATIENTS WITH GASTROESOPHAGEAL VARICEAL BLEEDING IN THE ICU: ANALYSIS OF 85 CASES IN A TERTIARY CARE CENTRE

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**Introduction and Objectives:** Variceal bleeding represents a challenge in the intensive care unit (ICU). This study describes the experience at a tertiary care center, evaluating clinical characteristics, the impact of early endoscopy (<12 hours), transfusion requirements, complications, and 6-week mortality.

**Patients and Methods:** Retrospective study of 85 patients with portal hypertension and gastroesophageal variceal bleeding admitted to the ICU between 2023 and 2024, all of whom underwent endoscopic intervention within 12 hours. Clinical variables, type of endoscopic therapy, bleeding control, transfusion requirements, ICU length of stay, rebleeding, infectious complications, and mortality were analyzed. Descriptive statistics, chi-square tests, and survival analysis were performed using SPSS.

**Results:** 281 endoscopies for gastrointestinal bleeding, 85 were due to variceal bleeding. Mean age was 64.14 years, 58.8% were male. Banding was performed in 85.9% of cases. Initial bleeding control was achieved in 92.9% of patients. Rebleeding occurred in 58.8%, and 6-week mortality was 18.8%, predominantly in patients with more advanced liver dysfunction (Child-Pugh score C, p<0.0001). The mean number of blood units transfused was 1.59. Patients who received more than 6 units had significantly higher mortality (68% vs. 13%, p<0.002) and longer ICU stays (p<0.004). Infections occurred in 21.2% of patients and were associated with increased rebleeding (p<0.014) and higher mortality (p<0.001).

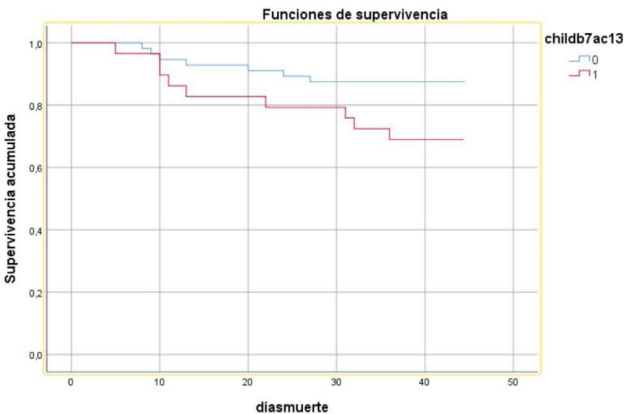
**Conclusions:** Early endoscopy is effective in achieving initial hemostasis, but prognosis remains poor in patients with advanced liver dysfunction. Massive transfusion and infectious complications are associated with worse outcomes. Early supportive care optimization and consideration of preemptive TIPS should be part of the management strategy.

**Conflict of interest:** None

Table 1. Patient characteristics (n=85)

|                                           |                |
|-------------------------------------------|----------------|
| Age, years (mean +DE)                     | 64.14 DE 1.1   |
| Male sex, n (%)                           | 50 (58.8)      |
| Child-Pugh score at admission, n (%)      |                |
| Child A                                   | 24 (27.9)      |
| Child B                                   | 36 (41.9)      |
| Child C                                   | 25 (29.1)      |
| Endoscopic band received, n (%)           |                |
| Endoscopic band ligation                  | 73 (85.9)      |
| Sclerotherapy                             | 8 (9.4)        |
| Other                                     | 3 (3.5)        |
| Initial bleeding control, n (%)           |                |
| Yes                                       | 79 (92.9)      |
| No                                        | 6 (7.1)        |
| Rebleeding, n (%)                         |                |
| Yes                                       | 50 (58.8)      |
| No                                        | 35 (41.2)      |
| ICU stay, days (mean +DE)                 | 3.75 (DE 6.57) |
| Red blood cell units transfused, mean +DE | 1.59 (1.73)    |
| 6-week mortality, n (%)                   |                |
| Yes                                       | 16 (18.8)      |
| No                                        | 69 (81.2)      |
| Complications, n (%)                      |                |
| Hepatic encephalopathy                    | 24 (28.2)      |
| infection                                 | 18 (21.2)      |
| Shock                                     | 21 (24.7)      |

6-week mortality



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DEMOGRAPHIC AND CLINICAL CHARACTERISTICS, AND DIAGNOSTIC-THERAPEUTIC MANAGEMENT OF PATIENTS WITH CHOLANGIOCARCINOMA AT A TERTIARY CARE CENTER

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**Introduction and Objectives:** Cholangiocarcinoma is an aggressive malignancy of the biliary tract that is frequently diagnosed at advanced stages, limiting access to curative treatment.

Describe the clinical profile, diagnostic workup, therapeutic strategies, and outcomes in patients treated for cholangiocarcinoma.

**Materials and Methods:** A retrospective, descriptive, cross-sectional analysis was conducted on 30 patients with a confirmed diagnosis of cholangiocarcinoma between 2020 and 2024. Variables included demographic details, clinical features, diagnostic modalities,