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Introduction and Objectives: Viral infections have been described to increase the risk of decompensation in patients with cirrhosis. We aimed to determine the impact of SARS-CoV-2 infection on clinical outcome of hospitalized patients with cirrhosis and to compare the performance of different prognostic models for predicting mortality.

Patients: We performed a prospective cohort study including 2211 hospitalized patients with confirmed SARS-CoV-2 infection from April 15, 2020 through October 1, 2020 in 38 Hospitals from 11 Latin American countries. We registered clinical and laboratory parameters of patients with and without cirrhosis. All patients were followed until discharge or death. We evaluated the prognostic performance of different scoring systems to predict mortality in patients with cirrhosis using ROC curves.

Results: Overall, 4.6%(CI 3.7-5.6) subjects had cirrhosis (n=96). Baseline Child-Turcotte-Pugh (CTP) class was assessed: CTP-A (23%), CTP-B (45%) and CTP-C (32%); median MELD-Na score was 19 (IQR 14-25). Mortality was 47% in patients with cirrhosis compared to 16% in those without cirrhosis (P<.0001). Cirrhosis was independently associated to death [OR 3.1(CI 1.9-4.8);P<.0001], adjusted by age, gender, and body mass index >30. The areas under the ROC curves for performance evaluation in predicting 28-days mortality for Chronic Liver Failure Consortium (CLIF-C), North American Consortium for the Study of End-Stage Liver Disease (NACSELD), CTP score and MELD-Na were 0.85, 0.75, 0.69, 0.67; respectively (P<.0001).

Conclusions: SARS-CoV-2 infection is associated with elevated mortality in patients with cirrhosis. CLIF-C had better performance in predicting mortality than NACSELD, CTP and MELD-Na in patients with cirrhosis and SARS-CoV-2 infection.Clinicaltrials.gov: NCT04358380.

P-14 EVALUATION AND SELECTION OF CANDIDATES FOR LIVER TRANSPLANTATION: AN ECONOMIC PERSPECTIVE. RETROSPECTIVE STUDY

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Background: Over the next 20 years, the number of patients on the waiting list for liver transplantation (LTx) is expected to increase by 23%, while pre-LTx costs should raise by 83%.

Objective: To evaluate direct medical costs of the pre-LTx period from the perspective of a tertiary care center.

Methods: The study included 104 adult patients wait-listed for deceased donor LTx between October 2012 and May 2016 whose treatment was fully provided at the study transplant center. Clinical and economic data were obtained from electronic medical records and from a hospital management software. Outcomes of interest and costs of patients on the waiting list were compared through the Kruskal-Wallis test. A generalized linear model with logit link function was used for multivariate analysis. *P*-values <0.05 were considered statistically significant.

Results: The costs of patients who underwent LTx ($8,879.83; 95% CI 6,735.24−11,707.27; $P < 0.001$) or who died while waiting ($6,464.73; 95% CI 3,845.75−10,867.28; $P = 0.04$) were higher than those of patients who were excluded from the list for any reason except death ($4,647.78; 95% CI 2,469.35−8,748.04; $P = 0.254$) or those who remained on the waiting list at the end of follow-up.

Conclusion: Although protocols of inclusion on the waiting list vary among transplant centers, similar approaches exist, and common problems should be addressed. The results of this study may help centers with similar socioeconomic realities adjust their transplant policies.

P-15 WAITING LIST FOR LIVER TRANSPLANTATIOS: CLINICAL AND ECONOMIC BURDEN, RETROSPECTIVE STUDY

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Background: Burden of disease is an indicator that relates to health status. United States (US) and European epidemiological data have shown that the burden of chronic liver disease has increased significantly in recent decades. There are no studies evaluating the impact of complications of chronic liver disease on the waiting list for deceased donor liver transplantation (LTx).

Objective: To determine the clinical and economic burden of complications of liver disease in wait-listed patients from the perspective of a transplant center.

Methods: The study retrospectively analyzed medical records of 104 patients wait-listed for deceased donor LTx from October 2012 to May 2016 and whose treatment was fully provided at the study transplant center. Clinical data were obtained from electronic medical records, while economic data were collected from a hospital management software. To allocate all direct medical costs, two methods were used: full absorption costing and micro-costing.