Lorena del Carmen Notari[3], Marina Agozino[4], Jose Luis Fernandez[4], Maria Margarita Anders[5], Nadia Grigera[5], Florencia Antinucci[5], Orlando Orozco Ganem[5], Maria Dolores Murga[6], Daniea Perez[6], Ana Palazzo[6], Liria Martinez Rejtman[7], Ivonne Giselle Duarte[8], Julio Vorobioff[9], Victoria Trevizan[9], Sofía Bulaty[9], Fernando Bessone[9], José Daniel Bosia[9], Silvia Mabel Borzi[10], Teodoro E. Stieben[11], Adriano Masola[11], Sebastian Eduardo Ferretti[12], Diego Arufe[13], Ezequiel Demirdjian[13], Maria Pia Raffa[13], Cintia Elizabet Vazquez[14], Pablo Ruiz[14], José Emanuel Martínez[15], Hugo Fainboim[16], Mirta Peralta[16], Leandro Alfredo Heffner[17], Andrea Odzak[17], Melisa Dirchwolf[18], Astrid Smud[19], Manuel Mendizabal[20], Carla Bellizzi[21], Diego Giunta[22], Marcelo Valverde[23,24], Martin Elizondo[23,24], Ezequiel Mauro[1], Ana Martinez[21], Jesica Tomatis[18], Andres Bruno[17], Agñel Ramos[12], Josefina Pages[20], Silvina Tevez[4], Salvatore Piano[25], Adrian Gadano[1,22], Sebastián Marciano[1,22]

[1] *Hospital Italiano de Buenos Aires, Liver Unit, CABA, Argentina*
[2] *Clinica Chapelco, San Martin de los Andes, Argentina*
[3] *Hospital Churruca Visca, CABA, Argentina, San Martin de los Andes, Argentina*
[4] *Sanatorio Güemes, CABA, Argentina*
[5] *Hospital Aleman, CABA, Argentina*
[6] *Hospital A.C. Padilla, San Miguel de Tucuman, Argentina*
[7] *Hospital T J Schestakow, Mendoza, Argentina*
[8] *Hospital 4 de Junio, Saenz Peña, Argentina*
[9] *Hospital provincial del Centenario, Rosario, Argentina*
[10] *Hospital Rossi, La Plata, Argentina*
[11] *Hospital San Martín, Paraná, Argentina*
[12] *Sanatorio Parque, Rosario, Argentina*
[13] *Sanatorio Sagrado Corazon, CABA, Argentina*
[14] *Hospital Regional de Rio Gallegos, Río Gallegos, Argentina*
[15] *Sanatorio Boratti, Posadas, Argentina*
[16] *Hospital Muñiz, CABA, Argentina*
[17] *Hospital Argerich, CABA, Argentina*
[18] *Hospital Privado de Rosario, Rosario, Argentina*
[19] *Hospital Italiano de Buenos Aires, Infectious Diseases Section, ABH, CABA, Argentina*
[20] *Hospital Universitario Austral, Pilar, Argentina*
[21] *Hospital Fernández, CABA, Argentina*
[22] *Hospital Italiano de Buenos Aires, Department of Research, CABA, Argentina*
[23] *Hospital de Clinicas, Montevideo, Uruguay*
[24] *Hospital Militar, Montevideo, Uruguay*
[25] *Unit of Internal Medicine and Hepatology, Department of Medicine, University of Padova, Padova, Italy*

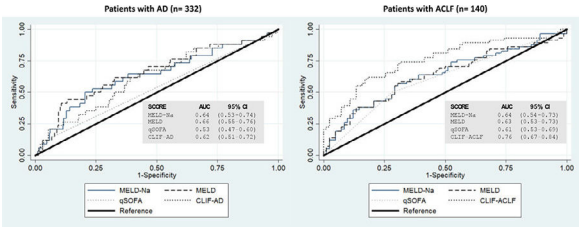
Background: Predicting short-term mortality in patients with cirrhosis and bacterial infections is challenging.

Aims: To compare the performance of various scores in predicting in-hospital mortality in this population.

Methods: We performed an analysis of the multicenter prospective cohort study of patients with cirrhosis with bacterial infections throughout Argentina and Uruguay (clinicatrials.gov.NCT03919032). Patients were classified according to the CLIF criteria as having ACLF or mere acute decompensation (AD). We evaluated the performance of scores of liver disease and infection severity in predicting in-hospital mortality. MELD, MELD-Na, and Quick SOFA (qSOFA) were computed in all patients. CLIF-AD was only computed in patients without ACLF, and CLIF-ACLF only in patients with ACLF. We plotted ROC curves and estimated their area under the curve (AUROC).

Results: We included 472 patients: 66% male, mean age 57 ± 12 years. Most frequent infections: SBP (30%) and urinary tract infection (25%). Overall, 332 (70%) patients had acute decompensation, and 140 (30%) ACLF. In-hospital mortality rate was 19%: 41% in patients with ACLF vs 10% in patients with AD (p<0,001). When we evaluated the AUROC of the entire cohort, MELD and MELD-Na performed similarly: 0.74 (95% CI 0.68-0.81) and 0.74 (95% CI 0.67-0.80), respectively; whereas qSOFA showed the lowest performance: 0.62 (95% CI 0.57-0.68). When evaluating only patients with ACLF, CLIF-ACLF performed significantly better than the other ones: AUROC 0.76 (95% CI 0.67-0.84, p =0.01). All scores performed poorly in patients with AD (Figure).

Conclusion: The best tool to predict in-hospital mortality in patients with infection-related ACLF was the CLIF-ACLF score. In patients with infection-related AD, all scores performed poorly. Evaluation of the scores performance is of paramount importance in different regions and for each complication of cirrhosis separately.



https://doi.org/10.1016/j.aohep.2021.100496

O-10 PRIMARY BILIARY CHOLANGITIS PATIENTS DIAGNOSED BY DIFFERENT COMBINATIONS OF THE DIAGNOSTIC CRITERIA PRESENT CLINICAL AND LABORATORY PECULIARITIES

Guilherme G.L. Cançado[1,2], Eduardo L.R. Cançado[3], Maria L.G. Ferraz[4], Cristiane A. Villela-Nogueira[5], Debora R.B. Terrabuio[3], Michelle H. Braga[3], Mateus J. Nardelli[1], Luciana C. Faria[1], Nathalia M.F. GOMES[4], ELZE M.G. Oliveira[4], Vivian Rotman[5], Maria Beatriz Oliveira[6], Simone M.C.F. Cunha[7], Daniel F. Mazo[8], Liliana S.C. Mendes[9], Claudia A.P. Ivantes[10], Valéria Faborges[11,12], Fabio H.L. Pace[13], Mario G. Pessoa[3], Izabelle V. Signorelli[14], Gabriela P. Coral[15], Paulo L. Bittencourt[16,17], Cynthia Levy[18], Cláudia A. Couto[1], Members of the Brazilian Cholestasis Study Group Consortium[1]

[1] *Hospital das Clínicas da Universidade Federal de Minas Gerais, Belo Horizonte, Brazil*
[2] *Hospital da Polícia Militar de Minas Gerais, Belo Horizonte, Brazil*
[3] *Departamento de Gastroenterologia, Faculdade de Medicina da Universidade de São Paulo, São Paulo, Brazil*
[4] *Disciplina de Gastroenterologia, Universidade Federal de São Paulo, São Paulo, Brazil*
[5] *Hospital Universitário Clementino Fraga Filho e Departamento de Clínica Médica da Faculdade de*

Medicina, Universidade Federal do Rio de Janeiro, Rio de Janeiro, Brazil
[6] *Ambulatório Municipal de Hepatites Virais de São José dos Campos, São José dos Campos, Brazil*
[7] *Hospital Universitário Professor Edgard Santos, Universidade Federal da Bahia, Salvador, Brazil*
[8] *Divisão de Gastroenterologia (Gastrocentro), Faculdade de Ciências Médicas, Universidade Estadual de Campinas, Campinas, São Paulo, Brazil*
[9] *Hospital de Base do Distrito Federal, Brasília, Brazil*
[10] *Serviço de Gastroenterologia, Hepatologia e Transplante Hepático, Hospital Nossa Senhora das Graças, Curitiba, Brazil*
[11] *Instituto de Gastroenterologia, Endoscopia e Proctologia, Uberlândia, Brazil*
[12] *Universidade Federal de Uberlândia, Uberlândia, Brazil*
[13] *Serviço de Gastroenterologia e Hepatologia, Universidade Federal de Juiz de Fora, Juiz de Fora, Minas Gerais, Brazil*
[14] *Hospital Universitário Cassiano Antônio Moraes, Universidade Federal do Espírito Santo, Vitória, Brazil*
[15] *Irmandade da Santa Casa de Misericórdia de Porto Alegre, Porto Alegre, Brazil*
[16] *Hospital Português, Salvador, Brazil*
[17] *Escola Bahiana de Medicina e Saúde Pública*
[18] *Division of Digestive Health and Liver Diseases, University of Miami Miller School of Medicine, Miami, Florida, United States of America*

Introduction: Primary biliary cholangitis (PBC) diagnosis is based on international criteria, which requires two of the following: (i) elevated alkaline phosphatase (AP), (ii) anti-mitochondrial antibody (AMA) and (iii) liver biopsy (BX) suggestive of PBC. It is still unclear if patients diagnosed by different criteria combinations present peculiarities, especially in highly-admixed populations.

Objectives: To investigate if patients diagnosed with PBC by different combinations of validated criteria present clinical or laboratory particularities.

Methods: The Brazilian Cholestasis Study Group database was reviewed to compare clinical, biochemical and histological characteristics of PBC between four groups diagnosed by: (1) AP ≥2x upper limit of normality (ULN) + presence of AMA, (2) AP ≥2x ULN + BX suggestive of PBC, (3) presence of AMA + BX suggestive of PBC and (4) all criteria.

Results: 482 patients with PBC were included (**Table 1**). Group-1 presented with higher levels of IgG, lower frequency of arterial hypertension (AH) and lower response to ursodeoxycholic acid (UDCA), while Group-2 had lower: age at diagnosis and HDL-C levels. Group-3 had higher: age at diagnosis, frequency of neoplasms, AH and response to UDCA; and lower: frequency of pruritus and jaundice, levels of aminotransferases, GGT and bilirubin, advanced liver disease and esophageal varices. Group-4 showed higher frequency of symptoms at presentation, especially pruritus.

Conclusion: PBC patients diagnosed by different combinations of established criteria may present singular features that can possibly impact in disease presentation and progression.

Table
Comparison of PBC Features according to Different Combinations of Diagnostic Criteria

Variables	Diagnostic Criteria				P-value
	Elevated AP + AMA positive	Elevated AP + BX positive	AMA positive + BX positive	All criteria	
Female sex	72 (96.0)	36 (94.7)	56 (94.9)	96 (96.0)	0.954[1]
Age (yr.)	63.1 ± 12.3	54.5 ± 13.9	63.9 ± 11.2	60.1 ± 11.3	**0.001**[3]
Age at diagnosis (yr.)	54.5 ± 13.9	48.6 ± 14.1*	57.6 ± 11.5*	52.3 ± 10.2	**0.023**[3]
Symptoms	54 (72.0)	26 (70.3)	25 (42.4)*	76 (76.0)*	**<0.001**[2]
Pruritus	38 (50.7)	20 (54.1)	16 (27.1)*	63 (63.0)*	**<0.001**[2]
Fatigue	27 (36.0)	17 (45.9)	15 (25.4)	42 (42.0)	0.155[1]
Jaundice	15 (20.0)	12 (31.6)	5 (8.5)*	28 (28.0)	**0.014**[2]
	25 (33.3)	15 (39.5)	29 (49.2)	40 (40.0)	0.327[2]
Extrahepatic manifestation					
Thyroiditis	12 (16.0)	6 (15.8)	16 (27.1)	19 (19.0)	0.374[2]
Rheumatoid Arthritis	4 (5.3)	2 (5.3)	4 (6.8)	3 (3.0)	0.676[1]
Sjögren Syndrome	4 (5.3)	4 (10.5)	5 (8.5)	12 (12.0)	0.494[2]
Neoplasms	2 (2.7)	3 (7.9)	9 (15.5)*	6 (6.0)	**0.046**[1]
Comorbidities					
Diabetes	11 (14.7)	7 (18.4)	5 (8.5)	11 (11.0)	0.454[2]
Arterial Hypertension	12 (16.0)*	10 (26.3)	22 (37.3)*	24 (24.0)	**0.044**[2]
Dyslipidemia	21 (28.0)	7 (18.9)	13 (22.0)	32 (32.0)	0.351[2]
Obesity	8 (10.7)	2 (5.3)	7 (11.9)	15 (15.2)	0.437[2]
Advanced Fibrosis	13 (44.8)	16 (48.5)	13 (23.6)*	41 (46.6)	**0.030**[2]
Laboratory					
AST/ULN	2.7 (1.8-3.6)	2.0 (1.5-3.5)	1.1 (0.8-1.6)	2.4 (1.6-4.4)	**<0.001**[4]
ALT/ULN	2.4 (1.3-4.4)	2.4 (1.5-3.8)	1.3 (0.9-1.9)	2.4 (1.6-4.2)	**<0.001**[4]
GGT/ULN	11.0 (5.8-21.7)	10.3 (5.8-17.9)	3.6 (1.7-7.9)	9.3 (5.1-15.8)	**<0.001**[4]
Total bilirubin (mg/dL)	1.1 (0.7-2.1)	1.2 (0.7-2.0)	0.7 (0.5-1.0)	1.0 (0.6-1.7)	**<0.001**[4]
Conjugated bilirubin (mg/dL)	0.7 (0.3-1.3)	0.6 (0.4-1.0)	0.3 (0.2-0.5)	0.5 (0.3-0.9)	**<0.001**[4]
Albumin (g/dL)	4.0 (3.5-4.2)	3.9 (3.6-4.2)	4.0 (3.8-4.3)	3.9 (3.5-4.2)	0.059[4]
Platelets count (10^9/L)	205 (145-276)	191 (112-265)	230 (200-276)	220 (168-272)	0.110[4]
Total cholesterol (mg/dL)	224 (191-265)	220 (191-251)	207 (185-231)	216 (191-267)	0.242[4]
HDL-cholesterol (mg/dL)	65 (48-82)	45 (36-71)	57 (50-69)	62 (48-80)	**0.012**[4]
Triglycerides (mg/dL)	111 (82-141)	92 (60-135)	111 (87-136)	111 (78-165)	0.493[4]
ANA ≥ 1:40	47 (66.2)	19 (52.8)	37 (71.2)	69 (70.4)	0.238[2]
ASMA ≥ 1:40	4 (6.5)	2 (6.1)	2 (4.2)	4 (4.6)	0.907[1]
IgG (mg/dL)	1702 (1344-1921)	1450 (1202-1755)	1421 (1218-1638)	1321 (1061-2248)	**0.032**[4]
IgM (mg/dL)	324 (210-478)	188 (123-387)	314 (191-454)	334 (205-438)	0.156[4]
Response Criteria					
Toronto	16 (40.0)*	11 (50.0)	24 (82.8)*	34 (52.3)	**0.005**[2]
Barcelona	30 (66.7)	19 (63.3)	18 (48.6)	48 (64.0)	0.344[2]
Paris-1	22 (48.9)	16 (55.2)	26 (70.3)	38 (50.7)	0.193[2]
Paris-2	9 (20.0)*	10 (34.5)	24 (64.9)*	21 (28.0)	**<0.001**[2]
POISE Trial	29 (64.4)	18 (60.0)	24 (64.9)	46 (61.3)	0.963[2]
Rotterdam	27 (61.4)	12 (48.0)	22 (68.6)	37 (59.7)	0.465[2]
Outcomes					
Liver cirrhosis	29 (45.3)	17 (47.2)	12 (20.7)*	35 (35.4)	**0.016**[2]
Esophageal varices	27 (43.5)	14 (50.0)	10 (20.8)*	29 (36.3)	**0.035**[2]
Transplantation	8 (10.7)	4 (10.5)	1 (1.7)	6 (6.0)	0.138[1]
Death	7 (14.9)	3 (9.4)	5 (11.1)	10 (12.7)	0.893[2]

AMA, anti-mitochondria autoantibody; ANA, anti-nuclear autoantibody; ASMA, anti-smooth muscle autoantibody; AP, alkaline phosphatase; AST, aspartate aminotransferase; ALT, alanine aminotransferase; BX, liver biopsy; HDL, high-density lipoprotein; IgG, immunoglobulin G; IgM, immunoglobulin M; ULN, upper limit of normality; Yr., years.*Variable associated with the statistically significant difference,[1]Fisher's test, [2]Chi-square test, [3]ANOVA, [4]Kruskal-Wallis test.

https://doi.org/10.1016/j.aohep.2021.100497

O-11 REMODELING OF IMMUNOLOGICAL BIOMARKERS IN PATIENTS WITH CHRONIC HEPATITIS C TREATED WITH DIRECTACTING ANTIVIRAL THERAPY

Isabela Gomes Ribeiro[1,2,3], Jordana Grazziela Alves Coelho-Dos-Reis[3,4], Jordana Rodrigues Barbosa Fradico[3], Ismael Artur da Costa-Rocha[3], Luciana Diniz Silva[1,2,5], Lucy Ana Santos Fonseca[1,2], Rhaissa Carvalho Said Stancioli[1,2], Andréa Teixeira-Carvalho[3], Olindo Assis Martins-Filho[3,*], Rosângela Teixeira[1,2,5]

[1] *Pós-graduação em Ciências Aplicadas da Saúde do Adulto, Faculdade de Medicina, Universidade Federal de Minas Gerais, Belo Horizonte, MG, Brazil*
[2] *Ambulatório de Hepatites Virais, Instituto Alfa de Gastroenterologia, Hospital das Clínicas/ Universidade Federal de Minas Gerais, Belo Horizonte, Minas Gerais, Brazil*
[3] *Grupo Integrado de Pesquisa em Biomarcadores, Instituto René Rachou, Fundação Oswaldo Cruz – FIOCRUZ-Minas, Belo Horizonte, MG, Brazil*
[4] *Laboratório de Virologia Básica e Aplicada, Instituto de Ciências Biológicas, Universidade Federal de Minas Gerais, Belo Horizonte, MG, Brazil*
[5] *Departamento de Clínica Médica, Faculdade de Medicina, Universidade Federal de Minas Gerais, Belo Horizonte, Minas Gerais, Brazil*