Table 1
Factors associated with quality studies in patients undergoing liver steatosis screening. (n=558)

Variable	IQR <40				IQR <30			
	Univariate OR (IC95%)	p	Multivariate OR (CI95%)	p	Univariate OR (CI95%)	p	Multivariate OR (CI95%)	p
XL probe	0.26 (0.18 – 0.38)	**≤0.001**	0.24 (0.14 – 0.39)	**≤0.001**	0.25 (0.17 – 0.36)	**≤0.001**	0.18 (0.10 – 0.33)	**≤0.001**
Obesity	0.51 (0.35 – 0.75)	**0.001**			0.57 (0.39 – 0.83)	**0.003**		
<54 years	0.62 (0.43 – 0.89)	**0.01**	0.67 (0.46 – 0.99)	**0.04**	0.81 (0.58 – 1.1)	0.26		
IQR kPa <30	0.42 (0.20 – 0.88)	**0.02**			0.35 (0.15 – 0.84)	**0.02**		
IQR kPa <10	0.74 (0.48 – 1.12)	0.178			0.63 (0.43 – 0.93)	**0.02**		
BMI <27kg/m2	0.57 (0.39 – 0.55)	**0.005**			0.61 (0.43 – 0.87)	**0.008**		

https://doi.org/10.1016/j.aohep.2021.100619

COMPARISON OF SEROLOGICAL MODELS OF LIVER FIBROSIS AGAINST TRANSIENT ELASTOGRAPHY BY FIBROSCAN® IN PATIENTS WITH NON-ALCOHOLIC FATTY LIVER DISEASE

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Introduction and Objectives: Liver fibrosis is the most important prognostic factor in nonalcoholic fatty liver disease (NAFLD). The study's objective is to compare the serological models of liver fibrosis (NAFLD-FS, FIB-4, BARD, APRI and AST/ALT) against transient elastography by FibroScan® in patients with NAFLD.

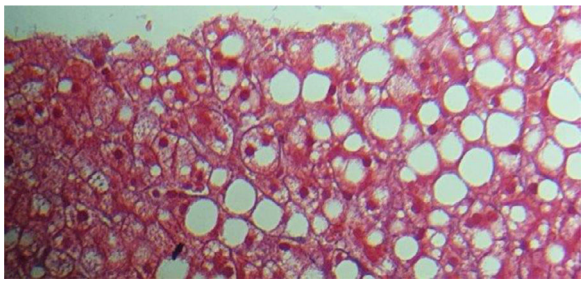
Materials and Methods: Observational, retrolective and cross-sectional study of records of patients diagnosed with liver steatosis by FibroScan® without significant alcohol consumption. A Pearson's correlation and heat maps were used for the correlation between results of FibroScan® and the serological models of liver fibrosis. ROC curves were analyzed to compare the serological models against FibroScan® as the gold standard for clinically significant liver fibrosis.

Results: Data from 976 files were collected, with a prevalence of 63% of liver steatosis by FibroScan® (CAP >232 dB/min) and 1.74% of significant liver fibrosis (LSM >7.0 kPa). In patients with NAFLD, a low positive correlation of NAFLD-FS (r=0.291; p<0.001) and BARD (r=0.021; p<0.001) and a very low positive correlation of APRI (r=0.184; p<0.001) with clinically significant liver fibrosis was reported. No correlation was observed with FIB-4 (r=-0.003; p=0.943) or with the AST/ALT ratio (r=-0.039; p=0.336). The NAFLD-FS reported an area under the curve (AUC) of 0.838 (95%CI 0.76-0.91) and the APRI of 0.797 (95%CI 0.68-0.92) compared to FibroScan® for clinically significant liver fibrosis (Figure 1).

Discussion: Liver biopsy is an invasive method and the gold standard for evaluating liver fibrosis; however, it is not exempt of complications. Transient elastography by FibroScan® is a non-invasive and validated method but with limited availability and accessibility. Serological models are widely available and can be easily used in daily practice. In a previous study, the NAFLD-FS reported an AUC of 0.72 (95% CI 0.60-0.83) compared against liver biopsy, which is comparable to the AUC reported in this study against FibroScan®.

Conclusions: The NAFLD-FS is the serological model for liver fibrosis with the best AUC and correlation with transient elastography in patients with NAFLD and is proposed as an evaluation method in places where FibroScan® or liver biopsy is not available.

The authors declare that there is no conflict of interest.



https://doi.org/10.1016/j.aohep.2021.100620

NEOBUXBAMIA TETETZO AS A CAUSE OF DRUG-INDUCED LIVER INJURY

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Introduction and Objectives: Drug-induced liver injury (DILI) is a rare clinical condition, the incidence is estimated from 14 to 19 cases per 100,000 population per year, it is responsible of 3 to 5% of jaundice hospitalizations, and it is the most frequent cause of acute liver failure in many of the western countries. Neobuxbaumia tetetzo is a species of flowering plant of the Cactaceae family, endemic to Mexico, distributed in Puebla and Oaxaca, and has been used within Mexican cuisine, without studies that establish the safety of its consumption, which predisposes to undocumented adverse effects, including probable liver injury.

Materials and Methods: The patient is a 19-year-old male, high school student and employee of a private company, single, originally from Tehuacán, Puebla, resident of Mexico City. Non-relevant family hereditary background. He denied experiencing any chronic degenerative diseases, allergies or traumas, but reported complications during an appendectomy in May of 2019. Has positive alcoholism, consuming it occasionally in social events; last consumption was seven months prior to the onset of symptoms. He denied the use of drugs, food supplements and herbalism. He began in June 30th of 2020 with asthenia, hyporexia, adinamia, nausea and unquantified fever, pain in epigastrium of moderate intensity, generalized pruritus, conjunctival jaundice and coluria were added, progressed to generalized jaundice, required hospitalization in August 2020. The laboratory results are Total Bilirubin 38.5 mg/dL, Direct bilirubin 26 mg/dL, ALT 60, AST 63, AP 329, GGT 33, General urine test that evidenced bilirubins 6 and urobilinogen 8. An ultrasonography and an abdominal tomography were performed, both reporting vesicular lithiasis, without obstruction or dilation of the bile duct. Subsequently, cholangioresonance was carried out on September 9, 2020, reporting liver gland with homogeneous parenchyma, bile duct without intra and extrahepatic dilation, gallbladder with the presence of lithic of 6.5 mm. Cholecystectomy and liver biopsy were performed, with histopathological result of gallbladder with chronic cholecystitis. Liver biopsy reporting: Hepatic parenchyma with preserved architecture, with few plasmatic and eosinophilic cells, and presence of severe intracanalicular and intracytoplasmic cholestasis corresponding to regenerative changes of grade 0 fibrosis on the Metavir scale and focal microvesicular steatosis, without regeneration nodules. Within its approach, serology Anti-Sm, IgM vs. CMV, IgM vs. Rubella, IgM vs. Toxoplasma, ANAs, anti Ro, SCL70 antibodies, HBV, HCV were negative.