Results: 359 patients with amyloidosis were included in the registry, of whom 16 (5% (CI 2.7-7.3)) had liver involvement. The most frequent types of amyloidosis were: AL 88% (14), AA 6% (1) and non-typed 6% (1). The median age at diagnosis was 64 years (IR 63-74), male 44% (7). The median albumin value was 3.0 gr/dL (IR 2.5-3.8), alkaline phosphatase 705 IU (IR 395-114), total bilirubin mg/dL 1.1 (IR 0.5-14.8), and more than 25% had jaundice. Thirty-one percent presented a cardiac compromise. The mortality rate in the study period was 56% (CI 30%-80%). When comparing patients with amyloidosis with and without liver involvement, mortality was higher in the liver involvement group (29% vs. 56%, p 0.02).

Conclusions: We present the first report in our region with adequate sampling that allows us to approximate the burden of this disease in relation to the liver. Hepatic infiltrative involvement has a high mortality rate in amyloidosis compared to those without liver involvement.

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P- 30 CLINICAL FEATURES, TREATMENT, AND SURVIVAL OF PATIENTS WITH BUDD-CHIARI SYNDROME IN A HEPATOLOGY COLOMBIAN CENTER

Ximena Morales[1], Daniel Rojas[1], Felipe Durán-Torres[2], Carolina Salinas[3], Leonardo Pérez[3], Andrés Murillo[3], Enrique Ponce[3], Jorge Ceballos[3], Martín Garzón[3], Geovanny Hernández-Cely[3], Cristina Torres[4], Adriana Varón[4], Andrés Murcia[5], Gilberto Mejía[5], José Gabriel Caviedes[5], Juan Manuel Pérez[5], Oscar Beltrán[3,4,6]

[1] *Fellow Gastroenterology and Digestive Endoscopy. LACARDIO/ Cardioinfantil Foundation - Universidad del Rosario. Bogotá, Colombia*
[2] *Epidemiologist - Universidad del Rosario. Bogotá, Colombia*
[3] *Department of Gastroenterology, LACARDIO/ Cardioinfantil Foundation. Bogotá, Colombia*
[4] *Department of Hepatology - LACARDIO / Cardioinfantil Foundation. Bogota, Colombia*
[5] *Department of Hepatobiliary Surgery- LACARDIO/ Cardioinfantil Foundation. Bogota, Colombia*
[6] *Department of Interventional Radiology- LACARDIO/ Cardioinfantil Foundation. Bogotá, Colombia*

Introduction and Objectives: Budd-Chiari syndrome is defined as the obstruction of the hepatic venous flow. In Colombia, there is limited evidence regarding the characterization of these patients. This study aims to describe the clinical features, management, and survival of these patients in a Colombian hepatology reference center. This study aimed to describe the clinical features, management, and survival of patients diagnosed with Budd-Chiari Syndrome at a Colombian Hospital from 2010 to 2021.

Materials and Methods: A retrospective descriptive longitudinal study of a cohort of patients with Budd-Chiari syndrome. Adult patients diagnosed with Budd-Chiari Syndrome were included. A descriptive analysis of the data was carried out.

Results: A total of 31 patients diagnosed with Budd-Chiari syndrome were included. 58.1% (n=18) were women. The median age was 27 years [interquartile range (IQR) 23-27]. Ascites was the main clinical manifestation (87.1%, n=27). At the time diagnosis was made, 48.4% (n=15) were cirrhotic. Acquired thrombophilia was the main prothrombotic risk factor (48.4%, n=15), with the antiphospholipid syndrome as the most frequent cause (73.3%). The principal location of the outflow obstruction was in the hepatic veins (73.3%, n=22). 48.3% (n=14) had a Class II Rotterdam score (intermediate prognosis). 80.6% (n=25) were on anticoagulation. A transjugular intrahepatic portosystemic shunt (TIPS) was placed in 6 patients (19.4%), and five patients received liver transplants (16.1%). 25.8% (n=8) died. The median time from diagnosis to death was 337.1 days [interquartile range (IQR) 46.5-647.5].

Conclusions: Budd-Chiari syndrome is an infrequent disease poorly described in Colombia. This study shows that this population has similar risk factors, clinical features, and mortality as it is described in other cohorts.

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P-31 SHORT-TERM EFFICACY AND SAFETY OF LOLA THERAPY IN PATIENTS WITH CIRRHOSIS AND MINIMAL HEPATIC ENCEPHALOPATHY: A REAL-LIFE COHORT STUDY

Fátima Higuera-De La Tijera[1], AB Moreno-Cobos[1], Christian Hinojosa-Segura[1], Diana Montemira-Orozco[1], Imran Cruz-Reyes[2], Juana Zavala-Ramírez[2], Daniel Santana-Vargas[2], Alfredo Servín-Caamaño[3], Juan Miguel Abdo-Francis[4], José Luis Pérez-Hernández[1]

[1] *Department of Gastroenterology and Hepatology, Hospital General de México "Dr. Eduardo Liceaga", Mexico City, México*
[2] *Sleep Disorders Clinic, Department of Experimental Medicine, Faculty of Medicine, UNAM, Mexico City, México*
[3] *Department of Internal Medicine, Hospital General de México "Dr. Eduardo Liceaga," Mexico City, México*
[4] *Angeles Acoxpa Hospital, Mexico City, México*

Introduction and Objectives: Minimal hepatic encephalopathy (MHE) is associated with the risk of accidents, falls, and impaired quality of life. Treatment with L-ornithine L-aspartate (LOLA) could be an effective strategy. This study aimed to verify the efficacy and safety of LOLA treatment in a real-life cohort of cirrhotic patients with MHE.

Materials and Methods: Cirrhotic patients with MHE were included. Those who had received any anti-ammoniacal measure or with alcohol consumption in the last six months, creatinine > 1.5 mg/dL, or previously known chronic kidney disease were excluded. The diagnosis of MHE was made using the psychometric hepatic encephalopathy score (PHES) and the critical flicker frequency (CFF). MHE patients received LOLA 6 g t.i.d. for three days and were reassessed with PHES and CFF. The project was approved by the local research and ethics committees.

Results: 98 cirrhotic patients were evaluated; 38 (38.8%) had baseline MHE, 26 (68.4%) women, mean age 53.3±8.8 years, median education nine years (range 0-15). According to Child-Pugh: 26 (68.4%) A, 9 (23.7%) B, and 3 (7.9%) C. The median MELD was 11 (range 6-21), and MELD-Na 12 (range 6-26). *Intention to treat analysis:* According to PHES, 30(78.9%) patients showed remission of MHE (p<0.0001). The incidence rate ratio for persisting with MHE was 8 per 38 person-times; that is, 0.2 (95%CI: 0.1-0.5; p<0.0001), with the fraction prevented after exposure to LOLA being 0.78 (95%CI: 0.55-0.90; p<0.0001). According to CFF, 29(76.3%) patients showed remission of MHE (p<0.0001). The incidence rate ratio for persisting with MHE was 9 per 38 person-times; that is, 0.2 (95%CI: 0.1-0.5; p<0.0001), with the fraction prevented after exposure to LOLA being 0.76 (95%CI: 0.51-0-89; p<0.0001). No adverse effects were reported.