ten cases. Autoimmune/Allergic features were present in seven patients. Resolution of liver injury occurred on an average of 183 days. No death was consigned. Liver function tests (LFTs) worsened during an initial period (>7 days) after drug withdrawal in six patients (cases 1,2,3,5,9 and 12), and two of them were treated with corticoids. Table 1 resumes data.

Conclusions: Hepatocellular acute liver injury with/without jaundice is the most common presentation of DILI linked to TKI. Clinicians should be aware that LFTs may worsen after drug withdrawal and monitor these patients before making a treatment decision.

Age /Sex

Table

	Age /Sex	TKI /Likelihood Score*	Indication	Latency (days)	Pattern	TB onset/peak	ALT U/L onset/peak	Resolution (days)
r1*	61/F	IMATINIB/B	Leukemia	92	HC	1/11	791/880	510
2*	73/F	IMATINIB/B	Renal cancer	124	HC	1.85/3.19	941/988	138
3*	58/M	MASITINIB/-	ALS	14	HC	0.4/0.4	351/436	230
4	50/F	BOSUTINIB/D	Leukemia	43	HC	0.3/0.3	233/233	169
5*	28/F	IMATINIB/B	Leukemia	176	HC	3.6/24	658/658	217
6	68/M	PAZOPANIB/C	Renal cancer	64	M	3.7/3.7	775/445	-
7	75/F	PAZOPANIB/C	Renal cancer	44	M	11/11	508/508	203
8	75/F	PAZOPANIB/C	Renal cancer	-	HC	3.8/3.8	403/403	204
9*	40/F	LENVATINIB/D	HCC	42	HC	2.5/12.6	750/750	120
10	65/F	IMATINIB/B	Breast cancer	150	HC	0.89/0.89	452/452	62
11	70/F	BOSUTINIB/D	Leukemia	112	-	0.3/0.3	341/341	83
12*	49/F	PALBOCICLIB/	Breast cancer	28	HC	0.37/0.96	281/1796	76
13	41/F	CABOZANTINIB/E	Renal cancer	84	HC	0.34/0.34	247/247	-

*Likelihood of association with DILI, based upon the known potential of the drug to cause such injury. HCC hepatocellular carcinoma; ALS amyotrophic lateral sclerosis; HC hepatocellular pattern; M mixed pattern; M male; F: female.

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O-8 CHARACTERIZATION AND EPIDEMIOLOGICAL CHANGES OF PATIENTS WITH HEPATITIS C VIRUS TREATED IN THE CHILEAN PUBLIC HEALTH SYSTEM FROM 2016 TO 2021.

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Introduction and Objectives: International studies have described an epidemiological change in patients with the hepatitis C virus (HCV), with greater involvement of young people and risk groups. The reality in Latin America, particularly in Chile, is unknown. This study aimed to epidemiologically characterize HCV patients treated in the Chilean public health system (period 2016-2021) and compare these characteristics in two periods (2016 - 2019 vs. 2020 - 2021).

Materials and Methods: Historical cohort was constructed based on national data and the Hospital del Salvador registry (Santiago, Chile) (n=410). All patients diagnosed with HCV treated in the Chilean public system (2016-2019) and those treated at Hospital del Salvador (2020-2021 period) were included. It was registered: year of diagnosis, age, sex, presence of cirrhosis, HCV genotype, co-infection with hepatitis B virus (HBV) and/or HIV, need for a liver transplant, or intratreatment dead. Both periods were compared using the Mann-Whitney U test or Fisher's exact test, as appropriate.

Results: 61.2% of patients were male, with a median age of 57 years. 73.5% presented genotype 1 and 11.6% genotype 4. There was a 19.3% coinfection with HIV. Only 1.4% had therapy failure at 24 weeks and 5.2% of patients underwent liver transplantation. When comparing the periods 2016 – 2019 vs. 2020 – 2021 a reduction in the median age 59 vs 49 (p<0.001) was observed, with a higher proportion of male gender 79.0% vs 51.7% (p<0.001). There is evidence of change in the proportion of the genotypes, with genotype four being the second most frequent after genotype 1. The presence of co-infection with HIV was 49.7% vs. 3.0% (p<0.001) and HBV/HIV 15.5% vs. 0.8% (p<0.001). There was no difference in the percentage of sustained viral response (Table 1).

Conclusions: There is an epidemiological change in HCV patients, which suggests different routes of transmission and the need to refocus screening.

Table 1: Result and comparison of socio-demographic and clinical variables between the periods 2016-2019 and 2020-2021.

	Total (n = 410)	Period 2016-2019 (n = 267)	Period 2020-2021 (n = 143)	p-value
Age (years), median (p25, p75)	57 (46, 64)	59 (52, 66)	49 (36, 61)	<0.001
Male, n(%)	251 (61.2%)	138 (51.7%)	113 (79.0%)	<0.001
Period years, n(%)				
2016	48 (11.7%)	-	-	
2017	26 (6.3%)	-	-	
2018	183 (44.6%)	-	-	
2019	10 (2.4%)	-	-	
2020	71 (17.3%)	-	-	
2021	72 (17.6%)	-	-	
Genotype, n (%)				<0.001
1	285 (73.5%)	209 (78.9%)	76 (61.8%)	
2	7 (1.8%)	4 (1.5%)	3 (2.4%)	
3	50 (12.9%)	36 (13.6%)	14 (11.4%)	
4	45 (11.6%)	15 (5.7%)	30 (24.4%)	
3 and 4	1 (0.3%)	1 (0.4%)	0 (0.0%)	
HBV co-infection, n (%)	17 (4.1%)	3 (1.1%)	14 (9.8%)	<0.001
HIV co-infection, n (%)	79 (19.3%)	8 (3.0%)	71 (49.7%)	<0.001
HIV-HBV co-infection, n (%)	15 (4.4%)	2 (0.8%)	13 (15.5%)	<0.001
Cirrhosis, n (%)	214 (54.7%)	183 (68.5%)	31 (25.0%)	<0.001
Failure at 12 weeks, n (%)	9 (2.8%)	8 (3.8%)	1 (0.9%)	0.17
Failure at 24 weeks, n (%)	4 (1.4%)	3 (1.5%)	1 (1.3%)	1.00
Use of rescue therapy, n (%)	139 (35.2%)	256 (95.9%)	0 (0.0%)	<0.001
Liver transplant, n (%)	21 (5.2%)	20 (7.5%)	1 (0.7%)	0.002
Kidney transplant, n (%)	1 (0.2%)	1 (0.4%)	0 (0.0%)	>0.999
Other outcomes, n (%)				0.495
Therapy failure	12 (3.4%)	10 (4.3%)	2 (1.6%)	
SVR	334 (93.3%)	216 (92.3%)	118 (95.2%)	
Discontinues treatment	5 (1.4%)	4 (1.7%)	1 (0.8%)	
Deads	7 (2.0%)	4 (1.7%)	3 (2.4%)	

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O-9 THE CHANGING EPIDEMIOLOGY OF HEPATOCELLULAR CARCINOMA IN SOUTH AMERICA: A REPORT FROM THE SOUTH AMERICAN LIVER RESEARCH NETWORK

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Introduction and Objectives: Hepatocellular carcinoma (HCC) is a leading cause of cancer-related death worldwide and most epidemiological data originates from resource-rich countries. We have previously described the epidemiology of HCC in South America through the South American Liver Research Network (SALRN). Here, we provide an update on the changing epidemiology of HCC in the continent over the last two years.

Materials and Methods: We evaluated HCC cases diagnosed between 2019 to 2021 in six centers from six countries in South America. A retrospective chart review of patient characteristics at the time of HCC diagnosis, including demographic, clinical and laboratory data, was completed. Diagnosis of HCC was made radiologically or histologically for all cases via institutional standards. Each center provided ethical approval for the study.

Results: A total of 339 HCC cases were included [Peru 37% (n = 125), Brazil 16% (n = 57), Chile 15% (n =51), Colombia, 14% (n = 48), Ecuador 9% (n = 29) and Argentina, 9% (n = 29)]. 61% of patients were male and the median age of diagnosis was 67 years (IQR 59-73). The most common risk factor for HCC was nonalcoholic fatty liver disease NAFLD (37%), followed by Hepatitis C infection (17%), alcohol use disorder (11%) and Hepatitis B infection (12%). The proportion of NAFLD-related HCC was much higher than in our previous report (37% compared to 11%). The majority of HCCs occurred in the setting of cirrhosis (80%), and the most common cause of non-cirrhotic HCC was HBV (31%) and NAFLD (28%). HBV-related HCC occurred at a younger age compared to other causes, with a median age of 46 years (IQR 36-64).

Conclusions: We report changes in the epidemiology of HCC in South America over the last 10 years, with a substantial increase in NAFLD-related HCC. HBV-related HCC still occurs at a much younger age when compared to other causes.

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O-10 SIMILAR RISK RECLASSIFICATION OF HCC RECURRENCE BETWEEN THE AFP SCORE AND METROTICKET 2.0 AT LISTING AND AT LAST REASSESSMENT

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Introduction and Objectives: Recently, two composite models, the alpha-fetoprotein (AFP) score and the Metroticket 2.0, have been proposed to select patients with hepatocellular carcinoma (HCC) for liver transplantation (LT). This study aimed to compare both models in their predictive performance of post-LT outcomes and their net reclassification of risk of recurrence.

Materials and Methods: This multicenter cohort study included 2444 adult patients who underwent LT for HCC in Europe and Latin America. The discrimination power of each model was estimated using adapted Harrell c-statistics and the NRI for recurrence was compared considering each model's threshold assessed at listing and at last pre-LT reassessment.

Results: At listing, although the Metroticket 2.0 showed a higher discrimination power for HCC recurrence compared to the AFP score, no differences were observed comparing each model's thresholds. At the last tumor evaluation, c-statistics did not significantly differ. Overall, predictive gaps and overlaps were observed between the model's thresholds. At listing and at last pre-LT reassessment, the Metroticket 2.0 did not show a significant gain on the NRI. Patients meeting both composite model's thresholds either within or beyond the Milan criteria showed the lowest risk of HCC recurrence [SHR of 0.28 (95% CI 0.22-0.36; P<.0001)], whereas a higher risk of recurrence was observed in patients exceeding both composite models, even meeting the Milan criteria.

Conclusions: the Metroticket 2.0 did not present a gain on risk reclassification of HCC recurrence over the AFP score at the time of listing or at the last tumor reassessment. The combination of these composite models might be a promising clinical approach.

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O-11 THE PUBLIC HEALTH POLICIES REDUCE THE LONG-TERM BURDEN OF ALCOHOL-ASSOCIATED LIVER DISEASE WORLDWIDE: DEVELOPMENT OF A PREPAREDNESS INDEX

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