

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 models 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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Introduction and Objectives: The long-term impact of alcohol-related public health policies (PHP) on the burden of liver disease is unclear. This study aimed to assess the association between alcohol-related PHP and alcohol-related health consequences; 2. To develop an instrument to quantify the establishment of alcohol-related PHP in each country.

Materials and Methods: We performed an ecological multinational study including 169 countries. We recorded socio-demographic data and the presence of alcohol-related PHP in each country from the WHO Global Information System of Alcohol and Health (GISAH) in 2010. Data on alcohol-related health consequences was collected from the Global Burden of Disease database (between 2010-2019). We classified the WHO categories into five domains to design an instrument with criteria for a low, moderate, and strong establishment of PHP. We estimated an incidence rate ratio (IRR) using multilevel generalized linear models with a Poisson family distribution. The models were adjusted by population size, age structure, and gross domestic product. We also estimated a preparedness index using multiple correspondence analysis.

Results: The table summarizes the final instrument. We included 169 countries; the median preparedness index was 54 [34.9-76.8].

The preparedness index was associated with lower alcohol-associated liver disease (ALD) mortality (IRR:0.25, 95%CI: 0.06-1.09, p=0.064), cancer mortality (IRR:0.22, 95%CI: 0.05-0.97, p=0.046), hepatocellular carcinoma (HCC) mortality (IRR:0.20, 95%CI: 0.04-0.95, p=0.043), and cardiovascular mortality (IRR:0.15, 95%CI: 0.04-0.61, p=0.008). There was also a trend to lower alcohol use disorder prevalence (IRR:0.25, 95%CI: 0.06-1.09, p=0.064). The highest linear associations were observed in the Americas and Africa, while Europe exhibits a nonlinear association.

Conclusions: The preparedness index on alcohol policies is a valuable instrument to assess the establishment and strength of PHP. Those countries with a higher number of PHP had lower mortality due to ALD, cancer, HCC, and cardiovascular diseases. Our results strongly encourage the development and implementation of PHP on alcohol consumption worldwide.

Table.- Five-item instrument to assess the strength of alcohol-related public health policies.

Item	WHO Categories	Low-level (0)	Moderate-level (1)	Strong-level (2)
National policy to fight harmful consequences of alcohol	- National Plan Written national policy (WNP) National action plan	Without WNP	A WNP without a National action plan	A WNP and National action plan
Control over production, pricing, and taxes	- Taxes control, pricing policies - National license, production, and selling control	Those without production control or taxes	Some regulations. Taxes in some alcoholic beverages	Strong regulations. Taxes in all alcoholic beverages
Marketing of alcoholic beverages and restrictions to alcohol access	- Control over advertising and promotion - Restrictions to alcohol access - National drinking age rule	Countries without policies to control ads, access or a national legal minimum age	<50% of policies to control ads and access. There is a drinking age rule.	> 50% of policies to control ads and access. There is a drinking age rule
Drink-driving policies and - Driving-related policies	No restrictions when driving a vehicle or effective penalties for drink driving	Restrictions on blood alcohol concentration when driving a vehicle and effective penalties for drink driving		countermeasures Zero tolerance to alcohol consumption when driving and effective penalties for drink driving
Monitoring and surveillance	- Monitoring systems	No monitoring systems and support	Monitoring systems or support	Monitoring systems and support

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O-12 CHARACTERIZATION AND UTILIZATION OF HCV-POSITIVE DONORS IN ARGENTINA

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Introduction and Objectives: Increased utilization of hepatitis C virus (HCV)-positive organ donors has been endorsed as one of several ways to combat organ shortages. However, HCV-positive donors remain poorly characterized. This study aimed to evaluate the