infections and 29/212 urinary tract infections. Bacterial isolation was obtained in 108/212 BIs: 35/108 (32.4%) were MRB. MRB was more frequent in cases with HCA (53%) and nosocomial (41%) infections compared with CA (22%) infections; (*P*=.0279). Mortality was 17.6% in patients without BIs, 28.8% in non-isolation BIs, 24.7% in non-MRB BIs and 51.4% in BIs due to MRB (*P*<.001). Multivariate analysis showed that mortality was significantly associated with Child-Pugh C, acute kidney injury, but mainly with MRB BIs (OR 4.41; 95% CI 1.94-10.2; *P*<.001).

Conclusions: MRB frequency was 32.4% among BIs with bacterial isolation. It represents an independent predictor for inpatient mortality.

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O-16 MELD-NA AND MELD3.0 HAVE THE BEST PERFORMANCE TO PREDICT THE 28-DAY RISK OF DEATH IN PATIENTS WITH SEVERE ALCOHOLIC HEPATITIS IN THE MEXICAN POPULATION

Fátima Higuera-De La Tijera[1], Claudia Dorantes-Nava[1], Alfredo Servín-Caamaño[2], Francisco Salas-Gordillo[1], Juan Miguel Abdo-Francis[3], Gabriela Gutiérrez-Reyes[4], P Diego-Salazar[1], MY Carmona-Castillo[1], Sandra Teutli-Carrion[1], EJ Medina-Avalos[1], A Servín-Higuera[1], José Luis Pérez-Hernández[1]

[1] *Gastroenterology and Hepatology Department, Mexican General Hospital "Dr. Eduardo Liceaga", México City*
[2] *Internal Medicine Department, Mexican General Hospital "Dr. Eduardo Liceaga", México City*
[3] *Ángeles Acoxpa Hospital, México City*
[4] *Liver, Pancreas And Motility Laboratory (HIPAM), Experimental Medicine Department, Faculty Of Medicine, Unam; Mexico City*

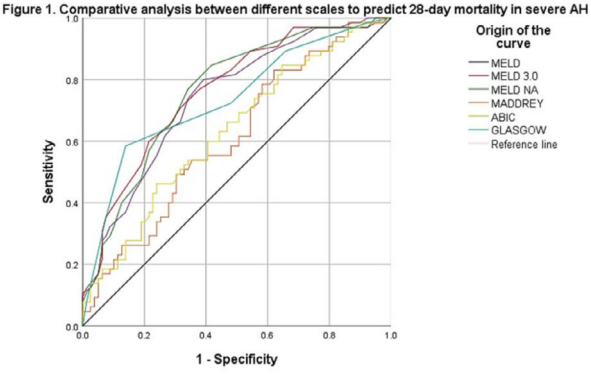
Introduction and Objectives: Severe alcoholic hepatitis (AH) has a high mortality rate, and currently, it is still a challenge to be able to establish the prognosis of these patients and their risk of death at admission in order to be able to offer better therapeutic alternatives that save a life in a timely manner. This study aimed to compare several prognostic scores to verify which of them has the best performance in predicting 28-day mortality at admission in patients with AH.

Materials and Methods: Observational, cohort study. Data were collected from patients with severe AH who were hospitalized between January 2010 to May 2022. MELD, MELDNa, MELD3.0, ABIC, Maddrey, Glasgow scale for AH were calculated with admission parameters, and their outcome was verified at 28 days. ROC curves were constructed to compare the different prognostic scales.

Results: 144 patients were included, 129 (89.6%) men, mean age 43.3±9.3 years, median grams of alcohol consumed/day were 320 (range: 60-1526). 65 (45.1%) died. The mean of MELD, MELDNa and MELD3.0 were higher among the deceased vs. survivors (33.5±7.5 vs. 27.1±6.2; 34.6±5.7 vs. 29.1±5.7; and 35.8±6.0 vs. 30.1±5.5 respectively; p<0.0001). The ROC curve analysis comparing the prognostic scales is shown in Figure 1.

Conclusions: AH mortality is high. MELDNa and MELD3.0 have the best performance for predicting on admission which patients with AH are at risk of dying in the next 28 days and can be useful tools for prioritizing patients who will require life-saving strategies, such as liver transplantation.

Figure 1. Comparative analysis between different scales to predict 28-day mortality in severe AH



Diagonal segments are generated by ties.

Scale	Area under the curve	95% confidence interval	*P*
MELD	0.743	0.663 - 0.823	< 0.0001
MELD 3.0	0.760	0.682 - 0.838	< 0.0001
MELDNa	0.761	0.682 - 0.839	< 0.0001
Maddrey	0.611	0.519 - 0.702	0.023
ABIC	0.630	0.539 - 0.721	0.007
Glasgow	0.735	0.652 - 0.818	< 0.0001

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O-17 STUDY OF THE ASSOCIATION BETWEEN SERUM LEVELS OF SYSTEMIC INFLAMMATORY MARKERS AND ADVANCED FIBROSIS STAGE IN INFECTED PATIENTS WITH HEPATITIS DELTA VIRUS GENOTYPE 3

Mauricio Campos[1], Juan Miguel Salcedo[4], Deusilene Vieira[4], Songeli Freire[1], Raymundo Paraná[1,2], María Isabel Schinoni[1,2,3]

[1] *Institute of Health Science. Federal University of Bahia. Bahía. Brazil*
[2] *Universitary Hospital of Federal University of Bahia. Bahía. Brazil*
[3] *Medical School of Bahia. UFBA. Bahia. Brazil*
[4] *Oswaldo Cruz Foundation (FIOCRUZ) of Rondônia, Brazil*

Introduction and Objectives: HDV-3 is responsible for outbreaks of fulminant hepatitis in northeastern South America. There are no studies investigating immune responses in relation to liver damage caused by HDV-3. This study aimed to investigate if systemic inflammatory molecules (SIM) are differentially expressed in patients with advanced fibrosis chronically infected with HDV genotype 3.

Materials and Methods: 61 patients coinfected with HBV/HDV-3 naive were included in this study. Diagnostic tests to screen for HBV/HDV infections were performed using standard immune serology testing. HDV quantification and genotyping was performed by semi-nested RT-PCR and RFLP methodology. 92 SIMs were measured by Proximity Extension Assay (PEA) technology(Proseek Multiplex Inflammation I assay). Shapiro-Wilk, Student's t test, Mann-Whitney tests and logistic regression analysis were used when appropriate.

Results: The median age was 41 years(18-59 years) and all patients were HBeAg negative. Advanced fibrosis or cirrhosis(F3/F4) was diagnosed by histological staging in 17 patients, while 44 presented with minimal or no fibrosis. Advanced necroinflammatory activity correlated positively with serum levels of AST and ALT (p=0.024 and 0.020, respectively). Established non-invasive fibrosis scores (APRI, FIB-4 and AST/ALT ratio) revealed low sensitivities and PPVs with AUROC maximum of 0.586. Among the 92 SIMs analyzed,

MCP4 (p = 0.032), CCL19(p = 0.024), EN.RAGE(p = 0.014), SCF(p = 0.01) and IL 18(p = 0.054) showed a positive correlation with the fibrosis stage. A combined score including CCL19 and MCP.4 revealed a sensitivity of 81% and an Odds Ratio of 2.202 for advanced fibrosis.

Conclusions: Standard non-invasive fibrosis scores showed poor performance in HDV G3 infection. We here suggest that the determination of CCL19 and MCP.4 may be used to identify patients with advanced fibrosis. Moreover, this study gives novel insights into the immunopathogenesis of HDV G3 infection.

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O-18 ETHNIC DISPARITIES IN HISPANIC POPULATION WITH ALCOHOL ASSOCIATED LIVER DISEASE AND TRANSPLANT ENLISTED PATIENTS: A RETROSPECTIVE STUDY OF TWO LARGE DATABASES IN THE UNITED STATES FROM 2011-2018

Gustavo Ayares[1], Luis Antonio Díaz[1], Eduardo Fuentes-López[2], Francisco Idalsoaga[1], Jorge Arnold[1], Thomas Cotter[3], Winston Dunn[4], Douglas Simonetto[5], Vijay Shah[5], Patrick Kamath[5], Ramon Bataller[6], Marco Arrese[1], Robert J. Wong[7], Ashwani K. Singal[8], Juan Pablo Arab[1]

[1] *Department of Gastroenterology, Medical School, Pontifical Catholic University of Chile, Santiago, Chile*
[2] *Health Sciences Department, Faculty of Medicine, Pontifical Catholic University of Chile, Santiago, Chile*
[3] *Division of Gastroenterology and Hepatology, UT Southwestern Medical Center, Texas, USA*
[4] *University of Kansas Medical Center, KS, USA*
[5] *Division of Gastroenterology and Hepatology, Mayo Clinic, Rochester, MN, USA*
[6] *Center for Liver Diseases, Division of Gastroenterology, Hepatology and Nutrition, University of Pittsburgh Medical Center, PA, USA*
[7] *Division of Gastroenterology and Hepatology, VA Palo Alto Healthcare System, Stanford University School of Medicine, Stanford, CA, USA*
[8] *Department of Medicine, University of South Dakota Sanford School of Medicine, Division of Transplant Hepatology, Avera Transplant Institute, Sioux Falls, SD, United States*

Introduction and Objectives: there are different variables in patients with alcohol associated liver disease (ALD) and enlisted patients for liver transplant (LT), such as ethnicity, that determine health disparities in access, morbidity and mortality. This study aimed to assess and measure the impact of ethnicity in ALD and patients enlisted for LT.

Materials and Methods: we conducted a retrospective study using U.S databases, the National Health and Nutrition Examination Survey (NHANES) and the United Network for Organ Sharing (UNOS) from 2011 to 2018. We created a multivariate model analyzing the clinical characteristics of the interviewed patients for NHANES. Alcohol consumption and ethnicity were self-reported. We also created a competing risks model for time to LT in enlisted patients.

Results: of the 39,156 interviewed patients, 17.1% identified as Hispanic. In this group, the prevalence of ALD was 9.0% and the average consumption of pure alcohol was 2.3 L/year. The multivariate-adjusted model showed that Hispanics were independently associated with a higher risk of ALD (OR 1.30; 95%CI: 1.05-1.60, p=0.018). Of the enlisted patients, 13.6% were Hispanic. White ethnicity, lower age, male sex, higher MELD score, renal failure, lower BMI, higher education and private insurance were associated with a higher rate of LT. Hispanics were independently associated with a lower LT (HR 0.80; 95%CI: 0.74-0.87, p<0.001).

Conclusions: ethnicity is an important factor in healthcare outcomes. This is a growing area of interest, and research should be carried out to better our understanding of the impact that these disparities have on patients. Studying ethnic minority groups is needed to enable researchers to face the challenges of reducing and ultimately eliminating health disparities.

Tabla 1. Competitive Risk Model for Patients Enlisted for Liver Transplant

Variable	Univariate Model	P Value	Adjusted Multivariate Model	P Value
	hazard ratio (IC 95%)			
Whites (ref)	ref	ref	ref	ref
vs Blacks	1.18 (1.07-1.31)	0.002	1.03 (0.87-1.23)	0.726
vs Hispanics	0.90 (0.85-0.95)	<0.001	0.80 (0.74-0.87)	**<0.001**
vs Asian	0.85 (0.72-1.00)	0.046	0.98 (0.82-1.19)	0.867
vs Other	0.83 (0.71-0.98)	0.026	0.82 (0.64-1.04)	0.100
Men	1.13 (1.08-1.18)	<0.001	1.01 (0.94-1.07)	0.875
Age at Enlistment	0.98 (0.98-0.99)	<0.001	0.99 (0.98-0.99)	**<0.001**
MELD (Model for End-Stage Liver disease)	1.26 (1.24-1.26)	<0.001	1.04 (1.03-1.05)	**<0.001**
Diabetes Mellitus	0.97 (0.92-1.02)	0.187	-	-
Hepatocellular carcinoma	1.02 (0.92-1.14)	0.66	-	-
Obesity	0.99 (0.98-0.99)	0.010	0.99 (0.98-0.99)	0.16
Renal Failure	1.60 (1.54-1.67)	<0.001	1.40 (1.32-1.47)	**<0.001**
Education <"High school"	ref	ref	ref	ref
Education "Some College"	1.03 (0.98-1.08)	0.195	0.99 (0.93-1.06)	0.860
Education "College-Bachelor"	1.07 (1.02-1.12)	0.006	1.04 (0.97-1.11)	0.263
Medicare	ref	ref	ref	ref
Medicaid	1.01 (0.93-1.11)	0.721	0.98 (0.89-1.09)	0.760
Private Insurance	1.18 (1.10-1.27)	<0.001	1.01 (0.93-1.10)	0.784

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O-19 COLLABORATIVE CARE TOWARDS MICROELIMINATION OF HEPATITIS C VIRUS IN A DIALYSIS POPULATION IN SOUTHERN BRAZIL

Hugo Cheinquer, Alexandre de Araujo, Dirceu da Silva Reis

Clinics Hospital of Porto Alegre, Porto Alegre, Brazil

Introduction and Objectives: Hepatitis C virus (HCV) eradication from dialysis facilities in a community using direct acting antivirals (DAAs) may be achieved more effectively under a collaborative care model, including a network of hepatologists, nephrologists and specialized dialysis staff. This study aimed to evaluate the prevalence of HCV infection in patients undergoing renal replacement therapy in all registered dialysis units operating in Rio Grande do Sul State (RS), in Southern Brazil. Furthermore, to implement a strategy to treat HCV infection locally at these units.

Materials and Methods: All dialysis units in RS State were contacted between January 2020 and January 2022 to provide results of anti-HCV screening in dialysis patients. Those with positive results were discussed via telemedicine with a team of two hepatologists and one nephrologist located in Clinics Hospital of Porto Alegre, a tertiary health care facility. Dialysis staff was instructed to test HCV RNA with polymerase chain reaction (PCR) and calculate FIB-4 and APRI scores. Viremic patients were selected for therapy and those with FIB-4 >3.25 and/or APRI >1.5 were required to undergo ultrasonography and/or elastography. DAA therapy was started locally by the dialysis unit staff under the supervision of the hepatologists.