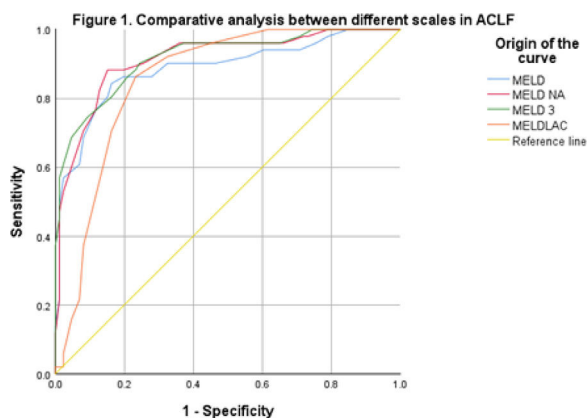square = 34.99, p <0.001. The mean survival by grades was 17 months for grade 1, 13 months for grade 2, and 5 months for grade 3.

Conclusions: MELD 3.0 scale showed better performance as a tool to evaluate severity and predict short-term mortality risk in ACLF patients.

Figure 1. Comparative analysis between different scales in ACLF

P-13 IMPACT OF SPONTANEOUS BACTERIAL PERITONITIS ON THE OUTCOME OF PATIENTS WITH HEPATIC CIRRHOSIS

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Introduction and Objectives: Spontaneous bacterial peritonitis (SBP) increases mortality, making it relevant to evaluate factors that negatively impact the outcome of patients who develop SBP. This study aimed to evaluate SBP as a risk factor in the outcome of patients with cirrhosis.

Materials and Methods: A retrospective and analytical study was conducted on patients with cirrhosis who developed SBP. The cause of cirrhosis, Child-Pugh score, Model for End-Stage Liver Disease (MELD) score, and MELD-Na score were evaluated. They were classified into early responders (ER) (more than 25% decrease in polymorphonuclear cells on the second day of effective antibiotic treatment), development of renal injury (RI), acute-on-chronic liver failure (ACLF), and 28-day mortality. Statistical analysis included evaluating the mortality rate using the Kaplan-Meier curve, log-rank test, considering significance at p 0.05. RI, ACLF, and non-early responders were independently compared.

Results: A total of 79 patients were included, 40 males (50.63%). The most common etiology was alcohol-related in 39 cases (49.36%), and Child-Pugh class C was observed in 67 cases (84.81%). Cephalosporins were used in 66 cases (83.54%), and carbapenems in 13 cases (16.45%). There were 6 deaths among early responders and 29 deaths among non-early responders, with a mean survival of 25.76 days for early responders versus 9.78 days for non-early responders, p < 0.001 (fig1). There were 2 deaths without ACLF and 33 deaths with ACLF, with a mean survival of 26.93 days without ACLF versus 14.6 days with ACLF, p < 0.001. There were 3 deaths without renal injury and 32 deaths with RI, with a mean survival of 25.65 days without RI versus 16.17 days with RI, p < 0.001.

Conclusions: SBP is associated with a high mortality rate. However, treatment response, the presence of ACLF, and RI have a significant impact on patient survival.

Figure 1. Area Under Receiver. Operating Characteristics Curve (AUROC) of for early responders and non-early responders for predicting 28-day survival.
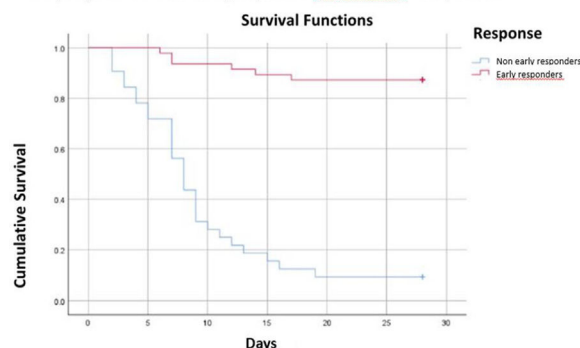
P-14 SPONTANEOUS BACTERIAL PERITONITIS IN CIRRHOTIC PATIENTS: PREVALENCE AND ANTIBIOTIC RESISTANCE PATTERNS

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Introduction and Objectives: Spontaneous bacterial peritonitis (SBP) is a leading cause of mortality in cirrhotic patients, and antibiotic resistance poses a significant challenge. This study aimed to assess the prevalence of SBP and the microbial patterns found in peritoneal fluid among hospitalized patients with cirrhosis.

Materials and Methods: All patients with decompensated cirrhosis, aged 18 years or older, who underwent propaedeutic paracentesis between 01/01/2017 and 13/09/2021 at a Brazilian university hospital, were included in the study.

Results: A total of 366 individuals were enrolled [(65.6% male; median age 61 (53-68) years]. The primary causes of cirrhosis were ethanolic (43.7%) and viral hepatitis (24.8%). SBP was diagnosed in 118 patients (18.6%). Only 16.1% of all patients received antibiotic prophylaxis, with norfloxacin being the preferred choice for 78% of them. Among the 34 peritoneal fluid samples with bacterial growth, 58 microorganisms were isolated. These included 50% classified as multi-sensitive (MS), 40% as multidrug-resistant (MDR), and 10% as extensively drug-resistant (XDR) bacteria. Gram-negative bacteria accounted for 62% of the isolates, while gram-positive bacteria made up 38%. The most frequently identified microorganisms were Escherichia coli for gram-negatives and the Staphylococcus ssp. for gram-positives. Meropenem demonstrated the highest overall sensitivity (79%), followed by piperacillin/tazobactam (67%). Conversely, ceftriaxone (48%) and ciprofloxacin (41%) exhibited the highest rates of resistance. Antibiotic prophylaxis did not influence resistance rates and no XDR bacteria were isolated from patients exposed to norfloxacin.

Conclusions: Our findings indicate that half of the SBP patients present with MDR or XDR bacteria. Empirical therapies such as meropenem and piperacillin/tazobactam show the greatest effectiveness. Additionally, antibiotic prophylaxis was not associated with an increase in antimicrobial resistance.

P-15 HELICOBACTER PYLORI AS A RISK FACTOR FOR THE DEVELOPMENT OF MANIFEST ENCEPHALOPATHY AND OTHER COMPLICATIONS IN PATIENTS WITH LIVER CIRRHOSIS AT THE EUGENIO ESPEJO HOSPITAL IN THE PERIOD MAY 2019-JUNE 2022

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Introduction and Objectives: It has been suggested that Helicobacter pylori contributes to hyperammonemia in cirrhosis and, with it, to Hepatic Encephalopathy, and the eradication of the bacteria decreases the concentration of ammonia in blood in these patients. Helicobacter pylori may be involved in persistent neurological impairment by promoting the release of involved pro-inflammatory and vasoactive substances, and it may also enter the brain through the oral-nasal-olfactory pathway or through infected circulating monocytes due to defective autophagy by disrupting the blood-brain barrier; producing reactive oxygen metabolites and even influencing the apoptotic process leading to neurodegeneration. This study aimed to describe Helicobacter pylori as a risk factor for the development of manifest encephalopathy and other complications in patients with liver cirrhosis.

Materials and Methods: Case-control study in patients treated at the Eugenio Espejo Hospital, with a diagnosis of liver cirrhosis in the period May 2019- June 2022. The case group consisted of cirrhotic patients with hepatic encephalopathy and the control group of cirrhotic patients without hepatic encephalopathy. The sample was 82 cases and 163 controls. Inferential statistics were applied, using chi-square for the relationship between categorical variables, statistical significance p less than 0.05.

Results: Hepatic encephalopathy occurs more frequently in the female sex with 51.5%, mainly in those over 50 years of age, with primary education, being the most frequent the alcoholic etiology. According to our study, it was determined that patients infected with Helicobacter pylori have a 4.4 fold increase in the possibility of developing manifest hepatic encephalopathy, more than uninfected patients. In addition, Helicobacter pylori infection was related to the presence of hepatocellular carcinoma as a complication, increasing the probability of having it by 2.6 times.

Conclusions: Helicobacter Pylori infection is a risk factor for the development of Hepatic Encephalopathy and is associated with various complications, mainly non-variceal upper gastrointestinal bleeding and hepatocellular carcinoma.

P- 16 HEPATOCELLULAR CARCINOMA IN CENTRAL AMERICA: A MULTIDISCIPLINARY APPROACH IN A COSTA RICAN COHORT

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Introduction and Objectives: Hepatocellular carcinoma (HCC) is a major problem in Latin America, but international guidelines do not consider the sociocultural heterogeneity and economic disparities in the region. We review the multidisciplinary approach and results from the largest cohort to date reporting on HCC in Central America.

Materials and Methods: Retrospective analysis of a cohort of HCC diagnosed radiographically or histologically and analysis of the multidisciplinary approach.

Results: from 10/2018 to 03/2023, 186 cirrhotic patients with HCC were evaluated. Distribution according to BCLC staging system was: 3, 46, 17, 22, and 12% for stage 0 to D, respectively. As initial treatment, most patients received transarterial therapy (TA) (n=79, 43%) followed by ablation (n=29, 16%), systemic treatment (ST) (n=11, 6%), surgical resection (n=9, 5%) and liver transplantation (LT) without bridging therapy (n=3, 2%). Based on current EASL guidelines, 49% of patients received a BCLC-recommended treatment strategy and 51% had a stage migration strategy based on multidisciplinary decisions: 0: 33% TA, A: 59% TA, B: 31% ST, C: 61% palliative and 17% TA. Main reasons for migration strategy were the location of the lesion (0/A to TA), risk factors for decompensation after TA (B to ST) and limited access to ST. Using selected criteria (<65 years, San Francisco criteria and no apparent contraindications), 21% (n=39) were candidates for LT: 38% (n=15) progressed or died outside the LT list (LTL), 10% (n=4) were managed with another treatment and remain off LTL, 26% receive LT (n=10) and 3% (n=1) drop out or die on LTL. Main reason for LT rate among candidates is low availability of donors and waiting time on list (mean rate 2018-2022: 5.72DD/pmp/y, mean waiting time: 236 days).

Conclusions: factors such as availability of resources and local experience frequently lead to multidisciplinary approaches adapted to health system and divergent from the established guidelines.
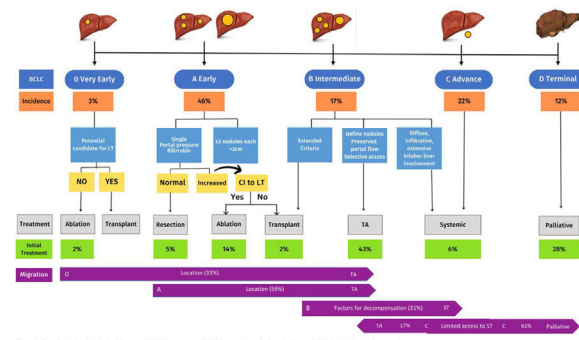

Figure 1. Flowchart showing the incidence and initial treatment of HCC (percentage of migration for each BCLC stage in purple arrows)