

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.

<https://doi.org/10.1016/j.aohep.2023.101201>

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.

<https://doi.org/10.1016/j.aohep.2023.101202>

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.

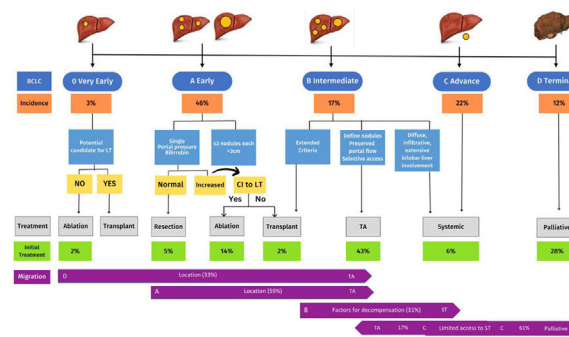


Figure 1. Flowchart showing the incidence and initial treatment of HCC (percentage of migration for each BCLC stage in purple arrows)

<https://doi.org/10.1016/j.aohep.2023.101203>