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ORAL

O-1
TRACKING OF VACCINE ESCAPE MUTATIONS IN PATIENTS WITH CHRONIC HBV IN TWO BRAZILIAN REGIONS

PACHECO SR,[1,2] SCHINONI MI,[2] MAGALHÃES MIA,[2] ZARIFE MAS,[2] STOCKER A,[2] PARANÁ R,[2] REIS MG,[1] SILVA LK[1]
[1] CENTRO DE PESQUISA GONÇALO MONIZ/LABORATÓRIO DE PATOLOGIA E BIOLOGIA MOLECULAR FIOCRUZ-BA.
[2] UNIVERSIDADE FEDERAL DA BAHIA/UFBA-SERVIÇO DE GASTROHEPATOLOGIA.

Introduction. Hepatitis B virus (HBV) is a chronic dynamic infection, which although there immunization programs and antiviral therapy available, there is a risk of emergence the mutations in the S gene have been identified as vaccine escape mutations, especially those located in the "a" determinant of HBsAg. **Objectives.** The aim of this study was to evaluate the vaccine escape mutations in patients with chronic hepatitis B in two reference centers in Hepatitis, Bahia (Northeast) and Acre (Northern) region Legal Amazon of Brazil. **Material and methods.** Was used tools of molecular biology and bioinformatics by nested PCR and direct sequencing of the target region is the reverse transcriptase (RT) P gene and vaccine escape mutations was region of the gene S of HBV. **Results.** We were sequenced 296 samples from patients with chronic HBV. Circulating genotypes in the two regions A, D and F, and the Northeast found the C genotype (C2). Mutations in the hydrophilic region of HBsAg were found in 21% in the Northeast region, of which 20.3% were vaccinated for HBV and 26% in the Northern region, no vaccination data. In the Northeast region, only one mutation was identified in 73.3% and in the North region in 61%. In the North region it presented a higher frequency of 3 mutations or more around 30% and in the Northeast region it was 3.5%. The most frequent mutation in the Northeast region was at position 100 corresponding to 50% of the frequency and at position 145 was 10%, 20% of the mutations found are related to vaccine escape. In the North region the most frequent mutation was in the position 133 corresponding to 26.9%, the mutation vaccine escape was 38.5%. **Conclusion.** In Brazil, few studies have carried out the survey of vaccine escape mutation and its epidemiological importance. The results demonstrate the importance of tracking and mutating the S gene vaccine, responsible for hidden hepatitis B infection, reactivation of hepatitis B, failure of the diagnostic test, and reinfection in recipients of orthotopic hepatic transplants infected with HBV.

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O-2
SURVEILLANCE FOR HEPATOCELLULAR CARCINOMA PROMOTES CANCER DIAGNOSIS AT EARLY STAGES AND IMPROVES SURVIVAL EMPLOYING BOTH, "LOCAL" OR "NON-LOCAL" ULTRASOUND

PIÑERO F,[1,11,12] MARCIANO S,[2] FERNÁNDEZ N,[5] SILVA J,[10] ZAMBELO Y,[8] COBOS M,[4] ZEREGA A,[9] RIDRUEJO E,[3] MIGUEZ C,[6] AMEIGEIRAS B,[14] D'AMICO C,[13] GAITE L,[7] BERMÚDEZ C,[2] ROSALES C,[10] ROMERO G,[6] MCCORMACK L,[4] REGGIARDO V,[8] COLOMBATO L,[5] GADANO A,[2] RUBINSTEIN F,[15] SILVA M[1]

[1] HOSPITAL UNIVERSITARIO AUSTRAL, UNIVERSIDAD AUSTRAL SCHOOL OF MEDICINE, ARGENTINA.
[2] HOSPITAL ITALIANO FROM BUENOS AIRES.
3 CENTRO DE EDUCACIÓN MÉDICA E INVESTIGACIONES CLÍNICAS NORBERTO QUIRNO (CEMIC).
[4] HOSPITAL ALEMÁN FROM BUENOS AIRES.
[5] HOSPITAL BRITÁNICO FROM BUENOS AIRES.
[6] HOSPITAL UDAONDO, BUENOS AIRES.
[7] CLÍNICA DE NEFROLOGÍA FROM SANTA FE.
[8] HOSPITAL DEL CENTENARIO, ROSARIO, SANTA FE.
[9] HOSPITAL PRIVADO FROM CÓRDOBA.
[10] HOSPITAL G RAWSON, SAN JUAN.
[11] SANATORIO TRINIDAD SAN ISIDRO. BUENOS AIRES.
[12] CLÍNICA PRIVADA SAN FERNANDO. BUENOS AIRES.
[13] CENTRO ESPECIALIDADES MÉDICAS AMBULATORIAS (CEMA), MAR DEL PLATA, BUENOS AIRES.
[14] HOSPITAL RAMOS MEJÍA, CIUDAD DE BUENOS AIRES.
[15] INSTITUTO DE EFECTIVIDAD CLÍNICA Y SANITARIA (IECS), DEPARTAMENTO DE DESARROLLO ACADÉMICO, HOSPITAL UNIVERSITARIO AUSTRAL.

Introduction. Although a randomized trial from Asia and other observational cohort studies have shown improvement on survival regarding surveillance for hepatocellular carcinoma (HCC), evidenced-based data in the daily practice is still lacking. Different international guidelines recommend that expert sonographers should perform ultrasound (US) biannual screening. However, US sensitivity has several threats, as it is "operator dependent". **Aims.** Therefore, our aim was to compare the effectiveness of local *vs*. non-local US screening upon survival and HCC staging at diagnosis in the daily practice in a multicenter cohort from Argentina. **Material and methods.** This study was conducted between 2009 and 2016 in 14 hospitals including a dual cohort of adult patients with newly diagnosed HCC (cohort 1 was a retrospective whereas cohort 2 was a prospective cohort study). Surveillance for HCC followed recommended international guidelines with biannual US. The site where the last US had taken place was categorized as local or external if it was done in or outside the local hospital. The main outcome of routine surveillance was HCC diagnosis at BCLC 0-A stages considered as potentially candidates for curative treatments. Thus, surveillance failure was defined as HCC diagnosis not meeting this tumor burden. A multivariate Cox regression analysis with hazard ratios (HR) and 95% CI was performed. Kaplan Meier survival curves were compared using the log-rank test. **Results.** A total of 533 consecutive patients with HCC were included (cohort 1 n = 478, cohort 2 n = 75). Overall, 62.4% of the cohort was under routine surveillance; local US was performed in 32.2% (n = 178). Patients who were under surveillance were younger, were predominantly HCV+ and had more frequently portal hypertension then those without routine surveillance. At HCC diagnosis, tumor number, largest nodule diameter, serum AFP values and presence of vascular or extrahepatic involvement were lower in patients undergoing surveillance than in those who did not. Routine surveillance was more likely to detect HCC at Barcelona Clinic Liver Cancer (BCLC) stages 0-A (70.7% *vs.* no-screening 32.7%; P < 0.0001), and so did local compared to non-local US (68% *vs*. 51%; P < 0.0001). Five-year survival was significantly higher among patients who were under surveillance compared to patients who were not screened (54% *vs*. 22%; HR 0.34, CI 0.25; 0.45). In univariate analysis, local US surveillance presented a better 5-year survival rate. However, in a sensitivity analysis, those patients under non-local US were less frequently under surveillance when compared to those under local surveillance (44.5% *vs*. 100%; P < 0.0001). Thus, the effect upon survival in patients in whom HCC surveillance was correctly done was not significantly different either with local or non-local US [HR 0.74 (CI 0.49; 1.13)]. Furthermore, rates of surveillance failure were similar between local or non-local US (32% *vs*. 26.3%; P = 0.25). **Conclusions.** Routine surveillance in the daily practice for HCC improved survival as a consequence of HCC diagnosis in early stages either with local or non-local US, thus offering curative opportunity.

O-3
FIRST 1,000 PATIENTS WITH HEPATITIS C TREATED WITH DIRECT-ACTING ANTI VIRAL DRUGS IN ARGENTINA

SOLARI J,* CORONEL E,* AQUINO R,* ROITMAN K,* MARTÍNEZ-MADRID D,* VIDIELLA G,* VILA M,** PAPALE R,*** CARRANZA J,*** MAULEN S****

* PROGRAMA NACIONAL DE CONTROL DE LAS HEPATITIS, MINISTERIO DE SALUD.
** ORGANIZACIÓN PANAMERICANA DE LA SALUD, ARGENTINA.
*** ADMINISTRACIÓN NACIONAL DE MEDICAMENTOS, ALIMENTOS Y TECNOLOGÍA MÉDICA.
**** DIRECTOR DE SIDA, MINISTERIO DE SALUD DE LA NACIÓN.

Introduction. In 2016, 1,068 patients with hepatitis C were treated in Argentina using direct-acting anti-viral drugs. These patients were treated through the National Hepatitis Program. **Objectives.** Characterize the population and evaluate safety and efficacy. **Material and methods.** Patients with advanced liver disease were treated. 1,068 treatments were assigned. 63% of Probirase (Richmond) and 37% of Sovaldi (Gilead) were purchased, in addition to daclatasvir. Results of end-of-treatment viral load in 907 patients and viral load after 12 weeks of treatment in 411 patients could be reported. **Results.** The city of Buenos Aires requested 57% of the orders.21% had co-infection with HIV. On which we obtained data of sustained viral response (SVR): 37% did not refer risk factors for hepatitis C, ever use of intravenous drugs 22%, received blood products 21%, 22% underwent medical procedures. Among the 1068 patients: 80% presented genotype 1, 7% genotype 2, 10% genotype 3 and 3% genotype 4. The overall end-of-treatment response (RFT) was 99.1% and the overall SVR was 94.1%. There were no significant differences in both the RFT rate and the SVR rate depending on whether one sofosbuvir or another was used. 245 adverse reactions were received: 77.9% were not serious. **Conclusions.** More than 1.000 patients received treatment from the Program without interruptions or commissions. The virological response was not modified depending on whether sofosbuvir from Gilead or Richmond was used.

O-4
A SIMPLE SCORE TO SELECT SORAFENIB TREATMENT CANDIDATES: A REPORT FROM THE SOUTH AMERICAN LIVER RESEARCH NETWORK

LEATHERS J,[1] BALDERRAMO D,[2] PRIETO J,[3] DIEHL F,[2] GONZALEZ-BALLERGA E,[4] FERREIRO MR,[4] CARRERA E,[5] BARREYRO F,[6] DIAZ-FERRER J,[7] SINGH D,[10] MATTOS AZ,[8] CARRILHO F,[9] DEBES J[10]

Introduction. There is limited knowledge about sorafenib use for hepatocellular carcinoma (HCC) in South America. **Objectives.** To evaluate treatment efficacy and predictors of survival, in patients with HCC treated with sorafenib in South America. **Material and methods.** We analyzed HCC cases treated with sorafenib from five countries within the South American Liver Research Network, between January 2010 and June 2017. The primary endpoint was overall survival (OS). Risk factors for decreased OS were assessed using Cox proportional hazard regression and log-rank tests. We designed a score based on Platelet-INR-Bilirubin (PIB) to assess survival in patients on sorafenib. **Results.** Of 1336 evaluated patients, 127 were treated with sorafenib. The median age of individuals was 65 years (IQR 55-71) and 70% were male. Median survival was 8 months (IQR 2-17). Variables associated with survival were total bilirubin >/< 3 mg/dL (2 *vs.* 8.5 months, p = 0.001), INR >/< 1.6 IU (5 *vs.* 8 months, p = 0.01), platelets >/< 250,000 mm^3 (2 *vs.* 8 months, p = 0.01), Barcelona Clinic Liver Cancer (BCLC) Stage (A/B, 13 months; C/D, 6 months, p = 0.008) and presence of any sorafenib-related side effects (11 *vs.* 2 months, p = 0.009). Patients with a PIB score of 1 or 2 had a median survival of 2 months whereas patients with a PIB score of 3 had a median survival of 10.5 months (Figure 1). **Conclusion.** Platelets, INR, total bilirubin, BCLC stage and presence of side effects were associated with survival on sorafenib. The PIB score may be useful for the selection of sorafenib treatment candidates in resource-limited settings.

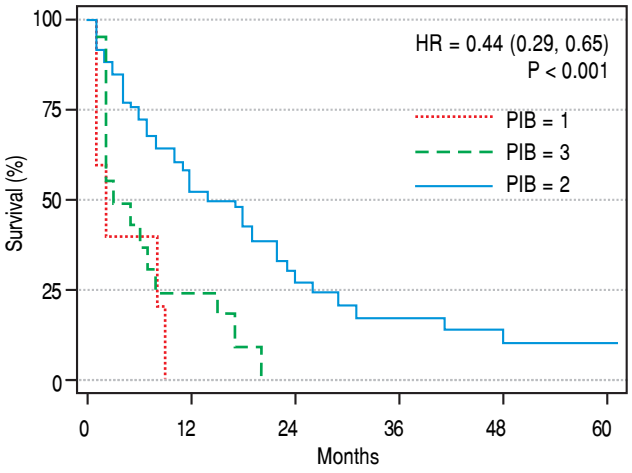

Figure 1 (O-4). *Kaplan-Meyer survival function for Platelet-INR-Bilirubin (PIB) score. Kaplan Meyer functions were performed using Cox proportional hazard regression and p-values were derived using the log-rank test. There were no patients with a PIB score of "0", five patients with a score of "1", 21 patients with a score of "2" and 61 patients with a score of "3."*

O-5
MICROBIOTA MODULATION BY SYMBIOTIC MODIFY GUT FLORA AND REDUCES OBESITY WITHOUT IMPROVEMENT OF FATTY LIVER IN OB OB MICE

BEZERRA-DUARTE SM,[1] TADEU-STEFANO J,[1] OLIVEIRA N,[1] FRANCO LAM,[2] MARTINS RC,[2] VELOSO-ALVES-PEREIRA I,[3] SABINO EC,[2] COGLIATI B,[3] CARRILHO FJ,[1] OLIVEIRA CP[1]

[1]*GASTROENTEROLOGY (LIM-07), UNIVERSITY OF SÃO PAULO SCHOOL OF MEDICINE, SAO PAULO, BRAZIL.*

[2]*INFECTIOUS DISEASE AND INSTITUTE OF TROPICAL MEDICINE, UNIVERSITY OF SÃO PAULO SCHOOL OF MEDICINE, SAO PAULO, BRAZIL.*

[3] *DEPARTMENT OF PATHOLOGY, SCHOOL OF VETERINARY MEDICINE AND ANIMAL SCIENCE, UNIVERSITY OF SÃO PAULO, SÃO PAULO.*

Background. Recent evidences suggest that changes in gut microbiota could improve metabolic disorders, including nonalcoholic fatty liver disease (NAFLD). **Aim.** This study aimed to examine the role of symbiotic supplementation in NAFLD and obesity in ob/ob mice. **Material and methods.** 20 ob/ob mice were divided into four groups: Obese Treated (OT), Obese Control (OC), Lean Treated (LT), Lean Control (LC). The OT and LT groups received symbiotic (Strains of Lactobacillus, Bifidobacterium and fructooligosaccharide) in the water for 8 wks. The OC and LC groups received only water. After 8 wks all animals were sacrificed, liver tissues were collected for histological analysis. Microbiome DNA was extracted from stool samples and sequenced using the Ion PGM Torrent platform. **Results.** The symbiotic supplementation reduced obesity. A difference between the initial and final body weight in OT group was seen. OT group gained lower weight compared to OC group (Figure 1). In microbiota analysis, the OT group showed a significant increase of Cyanobacteria and Enterobacteriaceae and decrease of Clostridiaceae, Turicibacter and Coprococcus compared to OC group. A higher abundance of Tenericutes, Mollicutes, Bacteroidaceae, Prevotellaceae, Bacteroides and Lactococcus and a significant reduction of Sutterella and Turicibater was seen in LT group. However, although body weight have reduced and changed in gut flora was seen, improvement in liver histology was observed in OT mice, however without significant difference. **Conclusions.** The symbiotic supplementation prevents excessive weight gain and modulated the

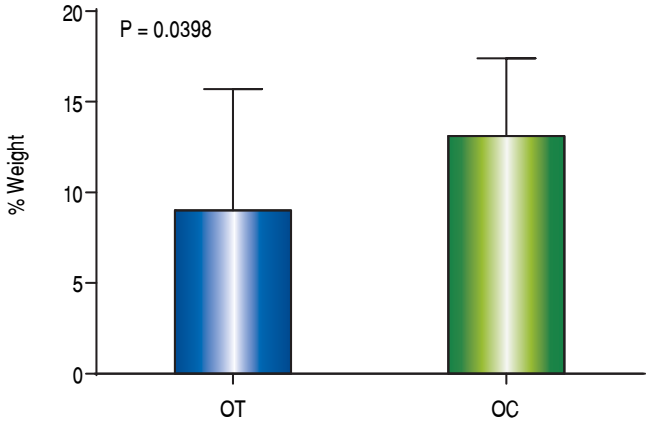

Figure 1 (O-5).

gut microbiota decreasing bacteria favor greater extraction of dietary energy, increasing bacteria promote protection of the intestinal barrier in obese mice and regulated the abundance of bacteria promote gastrointestinal disturbances in lean mice. Our results corroborate evidences that symbiotic supplementation may be beneficial in obesity and NAFLD treatment.

O-6
PLASMA PROTEOMIC SIGNATURE IN PATIENTS WITH NASH TREATED WITH OMEGA-3: PERSPECTIVES OF KNOWING MECHANISM OF ACTION

OKADA LSRR,[1] OLIVEIRA CP,[1] STEFANO JT,[1] NOGUEIRA MA,[1] SILVA IDCG,[2] CORDEIRO FB,[3] ALVES VAF,[4] TORRINHAS RS,[1] CARRILHO FJ,[1] WAITZBERG DL[1]

[1] DEPARTMENT OF GASTROENTEROLOGY (LIM-07/LIM-35), UNIVERSITY OF SAO PAULO SCHOOL OF MEDICINE, SAO PAULO, BRAZIL.
[2] LABORATORY OF MOLECULAR GYNECOLOGY, DEPARTMENT OF GYNECOLOGY, SAO PAULO FEDERAL UNIVERSITY, SAO PAULO, SP, BRAZIL.
[3] HUMAN REPRODUCTION SECTION, DIVISION OF UROLOGY, DEPARTMENT OF SURGERY, SAO PAULO FEDERAL UNIVERSITY, SAO PAULO, BRAZIL.
[4] DEPARTMENT OF PATHOLOGY (LIM-14), UNIVERSITY OF SAO PAULO SCHOOL OF MEDICINE, SAO PAULO, BRAZIL.

Background/Aim. Previous study by our group revealed that n-3 PUFA treatment modulates proteomic markers of Endoplasmic reticulum stress (ERS) and mitochondrial dysfunction in hepatic tissue suggesting decreased of cellular lipotoxicity. The aim of the present study is to evaluate if molecular pathways in plasma proteome could resemble those seen in the hepatic proteome after treatment with n-3 PUFA. **Material and methods.** We evaluated plasma proteomic profiles before and after n-3 PUFA therapy in 27 subjects with NASH. In a double-blind, randomized, placebo-controlled trial, patients with NASH received 6-month treatment with n-3 PUFA [0.945 g/day (64% ALA, 21% EPA, and 16% DHA)]. Plasma collected before and after-n-3 PUFA therapy was assessed using mass spectrometry for plasma proteomics. Differentially expressed protein (DEPs) were identified by using Morpheus software. Protein-protein interaction (PPI) networks of the DEPs were constructed by using Cytoscape/ClueGo software. **Results.** We identified increased expression of 26 proteins and decreased expression of 21 proteins in the plasma after n-3 PUFA treatment. After treatment the PPI network indicated significant functional enrichment of: regulation of protein processing (C4BPB, C6, CFB, CFH, CFI, CLEC3B, CPB2, F10, F12, F2, FCN3, GPLD1, HBB, HP, HPX, HRG, KLKB1, KNG1, KRT1, LTF, PLG, PROS1, VTN), negative regulation of lipoprotein oxidation (AGT, APOA1, APOD, APOE, APOM, C5, LBP, PON1), regulation of very-low-density lipoprotein particle remodeling (A2M, AGT, SERPINF2, SERPING1) and reverse cholesterol transport (ACTA2, AGT, APOA1, APOB, APOC2, APOD, APOE, APOH, APOM, C3,CLU, GPLD1, HPX, HRG, KNG1, LCAT, PF4, PLG, PON1, SERPINF2, TTR). **Conclusion.** These data corroborate our previous results of the hepatic proteome. The treatment with omega-3 PUFAs also demonstrated regulates plasma proteome, modulating lipid and lipoprotein metabolism, ERS and mitochondrial functions, suggesting a decrease in hepatic lipotoxicity.

O-7
B.A.R.C.O.S. (BRAZILIAN ARGENTINE HEPATITIS C COLLABORATIVE OBSERVATIONAL STUDY) REAL WORD DATA OF HCV TREATMENT WITH DACLATASVIR AND SOFOSBUVIR WITH OR WITHOUT RIBAVIRIN

RIDRUEJO E,[1,2,3] CHEINQUER H,[3,4] MARCIANO S,[5,6] MENDIZABAL M,[2,3] HERZ WOLFF F,[4] DE ARAUJO A,[4] COELHO BORGES S,[4] KLIEMANN D,[4] GARRAZTASUL P,[2] BERMÚDEZ C,[5] GADANO A,[5,6] SILVA M[2,3]

[1] SECCIÓN DE HEPATOLOGÍA, DEPARTAMENTO DE MEDICINA. CENTRO DE EDUCACIÓN MÉDICA E INVESTIGACIONES CLÍNICAS NORBERTO QUIRNO "CEMIC". CIUDAD AUTÓNOMA DE BUENOS AIRES, ARGENTINA.
[2] UNIDAD DE HEPATOLOGÍA Y TRASPLANTE DE HÍGADO. HOSPITAL UNIVERSITARIO AUSTRAL. PRESIDENTE DERQUI, BUENOS AIRES; ARGENTINA.
[3] LATIN AMERICAN LIVER RESEARCH EDUCATIONAL AND AWARENESS NETWORK (LALREAN).
[4] DIVISIÓN DE GASTROENTEROLOGÍA Y HEPATOLOGÍA, HOSPITAL DE CLÍNICAS DE PORTO ALEGRE, PORTO ALEGRE, BRASIL.
[5] UNIDAD DE HÍGADO. HOSPITAL ITALIANO DE BUENOS AIRES. CIUDAD AUTÓNOMA DE BUENOS AIRES, ARGENTINA.
[6] DEPARTAMENTO DE INVESTIGACIÓN. HOSPITAL ITALIANO DE BUENOS AIRES. CIUDAD AUTÓNOMA DE BUENOS AIRES, ARGENTINA.

Background. Real word data evaluating the effectiveness of direct acting antivirals (DAAs) in HCV treatment had been reported from different regions. Our aim was to evaluate the effectiveness of daclatasvir (DCV) and sofosbuvir (SOF) with or without ribavirin (w/wo RBV) in routine clinical practice in four large academic Hospitals from Argentina and Brazil. **Material and methods.** Data from patients included in a prospective multicenter cohort was analyzed. We included patients from Argentina and Brazil who received DCV/SOF w/wo RBV for 12 or 24 weeks according to international guidelines from January 1st 2015 to 30th April 2018. **Results.** From a total of 907 patients treated with DCV/SOF, 781 underwent 12 weeks post-treatment evaluation and were included in the analysis. Baseline characteristics and outcomes are presented in the Table 1. Overall SVR 12 rate was 95.5; SVR 12 rate was 94.8 in patients with cirrhosis, and 90.9 in patients with decompensated cirrhosis. During post-SVR12 follow-up 2 patients died from non liver related causes and 1 from liver related cause (HCC); 5 patients required a liver transplant and 12 developed an HCC. All these patients had achieved SVR 12. During post-SVR12 follow-up 15 patients developed hepatic decompensation: 6 ascites, 2 patients encephalopathy and 7 patients variceal bleeding. Five patients discontinued treatment before achieving the established duration: all of them achieved SVR 12. **Conclusion.** In a real life cohort that included patients with compensated and decompensated cirrhosis, treatment experienced and unfavorable genotypes the combination of DCV/SOF w/wo RBV for 12 or 24 weeks was safe and achieved high SVR 12 rates. **Funding.** Investigator Sponsored Research (ISR) trough Bristol-Myers Squibb.

Table 1 (O-7). Baseline characteristics and main outcomes.

	DCV/SOF (n=781)
Male sex (%)	54 (419/781)
Age (mean, yrs)	60 (SD 11)
Fibrosis stage 1,2,3,4 (%)	13/9/11/67 (102,70,88,502/762)
Decompensated cirrhosis (%)	26 (132/502)
In liver transplant waiting list (n)	24
GT1,1a,1b,2, 3,4 (%)	9/24/29/7/30/1 (71,186,220,57,233,7/781)
HIV coinfection (%)	12 (97/781)
Liver transplanted patients (%)	10 (77/781)
Previous non responders (%)	51 (398/781)
Duration 12/24 weeks (%)	72/28 (562,219/781)
With RBV (%)	55 (430/781)
Overall SVR12, (%)	95,5 (745/781)
SVR12, GT1,1a,1b,2, 3,4 (%)	95 (68/71), 95 (178/186), 96 (212/220), 94 (54/57), 94 (220/233), 100 (7/7)
Any adverse event (%)	22 (177/781)

O-8
OVERALL SURVIVAL (OS) UPDATE: 2-YEAR FOLLOW-UP FROM THE PHASE 3 RESORCE TRIAL OF REGORAFENIB FOR PATIENTS WITH HEPATOCELLULAR CARCINOMA (HCC) PROGRESSING ON SORAFENIB

SILVA M,[1]. CARRILHO FJ,[2]. MERLE P,[3]. GRANITO A,[4] HUANG Y-H,[5] BODOKY G,[6] YOKOSUKA O,[7] ROSMORDUC O,[8] BREDER V,[9] GEROLAMI R,[10] MASI G,[11] ROSS PJ,[12] QIN S,[13] SONG T,[14] BRONOWICKI J-P,[15] OLLIVIER-HOURMAND I,[16] KUDO M,[17] LEBERRE M-A,[18] BAUMHAUER A,[19] MEINHARDT G,[20] HAN G,[21] BRUIX J, ON BEHALF OF THE RESORCE INVESTIGATORS[22]

[1] HEPATOLOGY AND LIVER TRANSPLANT UNIT, HOSPITAL UNIVERSITARIO AUSTRAL, UNIVERSIDAD AUSTRAL, PILAR, ARGENTINA.
[2] DEPARTMENT OF GASTROENTEROLOGY, HOSPITAL DAS CLÍNICAS, FACULDADE DE MEDICINA, UNIVERSIDADE DE SÃO PAULO, SÃO PAULO, BRAZIL.
[3] GROUPEMENT HOSPITALIER LYON NORD, HEPATOLOGY UNIT, LYON, FRANCE.
[4] DEPARTMENT OF MEDICAL AND SURGICAL SCIENCES, UNIVERSITY OF BOLOGNA, S. ORSOLA-MALPIGHI HOSPITAL, BOLOGNA, ITALY.
[5] DIVISION OF GASTROENTEROLOGY AND HEPATOLOGY, TAIPEI VETERANS GENERAL HOSPITAL; INSTITUTE OF CLINICAL MEDICINE, NATIONAL YANG-MING UNIVERSITY, TAIPEI, TAIWAN.
[6] DEPARTMENT OF ONCOLOGY, ST. LASZLO TEACHING HOSPITAL, BUDAPEST, HUNGARY.
[7] DEPARTMENT OF GASTROENTEROLOGY AND NEPHROLOGY, CHIBA UNIVERSITY, CHIBA, JAPAN.
[8] DEPARTMENT OF GASTROENTEROLOGY AND HEPATOLOGY, HÔPITAL DE LA PITIÉ-SALPÉTRIÈRE, ASSISTANCE PUBLIQUE-HÔPITAUX DE PARIS AND UNIVERSITÉ PIERRE ET MARIE CURIE, SORBONNE UNIVERSITÉS, PARIS, FRANCE.
[9] DEPARTMENT OF CLINICAL BIOTECHNOLOGIES, NATIONAL MEDICAL RESEARCH CENTER OF ONCOLOGY N.A.N.BLOKHIN, MOSCOW, RUSSIAN FEDERATION.
[10] DEPARTMENT OF HEPATOGASTROENTEROLOGY, CHU TIMONE, UNIVERSITÉ DE LA MÉDITERRANÉE, MARSEILLE, FRANCE.
[11] DEPARTMENT OF TRANSLATIONAL RESEARCH AND NEW TECHNOLOGIES IN MEDICINE AND SURGERY, AZIENDA OSPEDALIERO-UNIVERSITARIA PISANA, PISA, ITALY.
[12] DEPARTMENT OF MEDICAL ONCOLOGY, KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST, LONDON, UNITED KINGDOM.
[13] DEPARTMENT OF MEDICAL ONCOLOGY, CHINESE PEOPLE'S LIBERATION ARMY CANCER CENTER OF NANJING BAYI HOSPITAL, NANJING, CHINA.
[14] DEPARTMENT OF HEPATOBILIARY TUMORS, TIANJIN MEDICAL UNIVERSITY CANCER HOSPITAL, TIANJIN, CHINA.
[15] HÉPATOGASTROENTÉROLOGIE, INSERM 954, CHU DE NANCY, UNIVERSITÉ DE LORRAINE, NANCY, FRANCE.
[16] SERVICE D'HÉPATOGASTROENTÉROLOGIE, CHU, CAEN, FRANCE.
[17] DEPARTMENT OF GASTROENTEROLOGY AND HEPATOLOGY, KINDAI UNIVERSITY FACULTY OF MEDICINE, OSAKA, JAPAN.
[18] PHARMACEUTICALS DIVISION, BAYER HEALTHCARE SAS, LOOS, FRANCE.
[19] PHARMACEUTICALS DIVISION, BAYER AG, LEVERKUSEN, GERMANY.
[20] CLINICAL DEVELOPMENT ONCOLOGY, BAYER HEALTHCARE PHARMACEUTICALS, WHIPPANY, NJ, USA.
[21] DEPARTMENT OF LIVER DISEASE AND DIGESTIVE INTERVENTIONAL RADIOLOGY, NATIONAL CLINICAL RESEARCH CENTER FOR DIGESTIVE DISEASE, XIJING HOSPITAL OF DIGESTIVE DISEASES, XIJING HOSPITAL, FOURTH MILITARY MEDICAL UNIVERSITY, XI'AN, CHINA.
[22] BCLC GROUP, LIVER UNIT, HOSPITAL CLINIC, UNIVERSITY OF BARCELONA, IDIBAPS, CIBEREHD, BARCELONA, SPAIN.

Introduction. In the phase 3 RESORCE trial, regorafenib improved OS compared with placebo in patients with unresectable HCC who progressed during sorafenib treatment. The most common regorafenib-related adverse events were hand-foot skin reaction, diarrhea, fatigue, hypertension, and anorexia, consistent with the known safety profile of regorafenib. **Objectives.** We present an updated OS analysis from RESORCE, nearly 2 years after the primary analysis. **Material and methods.** Patients with Barcelona Clinic Liver Cancer stage B or C HCC with radiologic progression on sorafenib, Child-Pugh A liver function, and Eastern Cooperative Oncology Group performance status 0-1 were randomized 2:1 to regorafenib 160 mg/day or placebo for Weeks 1-3 of each 4-week cycle until radiologic or symptomatic progression, death, or unacceptable toxicity. The data cut-off for the primary analysis was February 29, 2016; the data cut-off for this updated OS analysis was January 14, 2018. Hazard ratios (HRs) and 95% confidence intervals (CIs) were derived using the Cox model. **Results.** The updated HR for OS was 0.62 (Table 1). Estimated OS rates (regorafenib *vs.* placebo) at 12, 18, and 30 months were 47% *vs.* 28%, 32% *vs.* 15%, and 16% *vs.* 8%, respectively. Results for OS favored regorafenib in all pre-planned subgroup analyses. **Conclusions.**

Table 1 (O-8).

OS Primary analysis (February 29, 2016)		Updated analysis (January 14, 2018)		
Regorafenib n = 379	Placebo n = 194	Regorafenib n = 379	Placebo n = 194	
Patients with event, n (%)	233 (61)	140 (72)	317 (84)	174 (90)
Median OS (95% CI), months	10.6 (9.1, 12.1)	7.8 (6.3, 8.8)	10.7 (9.1, 12.2)	7.9 (6.4, 9.0)
HR (95% CI); 1-sided P-value	0.62 (0.50, 0.78); < 0.0001	0.62 (0.51, 0.75); < 0.0001		

The updated OS analysis of the RESORCE trial, carried out nearly 2 years after the primary analysis, confirms the primary results showing that regorafenib prolongs survival for patients with HCC who have progressed on sorafenib treatment. **Conflicts of Interest.** MS has received grants from Bayer, Bristol-Myers Squibb, and MSD; and advisory fees from AbbVie, Bristol-Myers Squibb, MSD, and Gilead Sciences. FJC reports no conflicts of interest. PM reports no conflicts of interest. AG has received consultancy fees from Bayer. Y-HH reports no conflicts of interest. GB has received advisory and consultancy fees from Bayer, Ipsen, Janssen, Lilly, Novartis, Pfizer, Roche, and Servier. OY has received grants from Astellas, Bayer, Bristol-Myers Squibb, Daiichi Sankyo, Sumitomo Dainippon Pharma, Eisai, Gilead Sciences, MSD, Nippon Kayaku, Mitsubishi Tanabe Pharma, Takeda, and Chugai Pharma. OR has received honoraria from Bayer, Eisai, and Transgene; and personal fees from Bristol-Myers Squibb. VB has received honoraria from Bayer, Boehringer Ingelheim, Bristol-Myers Squibb, and MSD; and advisory and consultancy fees from Bayer, Boehringer Ingelheim, Bristol-Myers Squibb, Eisai, and Roche. RG has received advisory and consultancy fees from Bayer. GM has received advisory and consultancy fees from Bayer. PJR has received grants from Sanofi; honoraria from Amgen, Bayer, Celgene, MSD, Merck Serono, and Sirtex; and advisory and consultancy fees from Baxalta, Bristol-Myers Squibb, Celgene, Sirtex and Shire. SQ reports no conflicts of interest. TS reports no conflicts of interest. J-PB has received honoraria, advisory and consultancy fees from Bayer. IO-H has received grants from AbbVie and MSD; honoraria from Bayer; and speaker fees from Bayer and Gilead Sciences. MK has received grants from AbbVie, Bayer, Chugai Pharma, Daiichi Sankyo, Eisai, MSD, Otsuka, Sumitomo Dainippon Pharma, Taiho Pharmaceutical, and Takeda; advisory fees from Bayer, Bristol-Myers Squibb, Chugai Pharma, Kowa, MSD, and Taiho Pharmaceutical; and honoraria from Ajinomoto, Bayer, Eisai, and MSD. M-ALB is an employee of Bayer. AB is an employee of Bayer. GM is an employee and owns stock with Bayer. GH has received grants, advisory fees, consultancy fees, and honoraria from Bayer. JB has received grants from Bayer and BTG; and consultancy fees from Daiichi Sankyo, ArQule, Bayer, Abbot, Bristol-Myers Squibb, GlaxoSmithKline, Lilly, Kowa, Novartis, Roche, Onxeo, and Sirtex; and advisory fees from BTG and Novartis

O-9
VALIDATION OF A MODEL PREDICTING PATIENT AND GRAFT SURVIVAL AFTER LIVER TRANSPLANTATION: THE DONOR RISK INDEX (DRI), A USEFUL TOOL IN LATIN AMERICA

ZAPATA R, GINESTA A, RIUS M, GÓMEZ F, SANHUEZA E, CONTRERAS-HUMERES R, RENCORET G, VIVANCO M, PALACIOS JM
UNIDAD DE TRASPLANTE HEPÁTICO. CLÍNICA ALEMANA DE SANTIAGO. FACULTAD DE MEDICINA, UNIVERSIDAD DEL DESARROLLO. SANTIAGO, CHILE.

Background. Orthotopic liver transplantation (OLT) is the only life-saving option for patients (pt) with severe liver diseases. The progressive organ shortage and increase in the waiting list, has led to the use of marginal organs. The need of objective scores to assess the donor (D) has become necessary. The Donor Risk Index (DRI), developed in 2006 (Feng, *et al*. *Am J Transp*), considers 7 D characteristics (age; height, graft type, race, cause of death, cold ischemia time, organ location, donation after cardiac death), and has served as a useful metric of D quality predicting pt/graft outcomes at 3, 12 and 36 months after OLT but only validated in some North American and European centers. There is still debate on its clinical usefulness and scarcity of data in Latin-American countries. **Aim.** To assess and validate DRI as a prognostic model of survival after OLT in Chile with current MELD-based liver allocation rules. **Material and methods.** Adult OLT performed in Clínica Alemana between 2001-2017. Biodemographic and clinical data from D and R were analyzed from a prospectively built database. DRI calculated for each D and correlated with R data. Statistical analysis through survival curves; comparisons between groups (T Student; $p < 0.05$). **Results.** 155 OLT. Overall pt survival at 3, 12 and 36 months: 94%, 91% and 85% respectively. R and D data: (Table 1). 68% D were Local (close to OLT center < 50 km); 17% Regional (51-200 km) and 14% National (> 200 km away). Local D had a shorter ischemia time (6.55 ± 0.08 h) than Regional or National D (809 ± 0.1 and 8.56 ± 0,09 hrs, respectively, p< 0,0001). Mean DRI from Local D (1.28 ± 0.24) was lower than National DRI (1.63 ± 0.27; $P < 0.0001$). A D with a DRI < 1.5 (given to R with mean MELD: 20.6 points) correlated with a 3, 12 and 36 months survival of 94%, 93% and 88% respectively. A D with a DRI > 1.5 (given to R with mean MELD score: 18.5 points) correlated with a significantly lower pt survival of 90%, 86% and 77% respectively ($p = 0.02$). **Conclusions.** Based on this cohort experience in Latin America, an OLT with a R with a lower DRI score is correlated with a significantly better survival after OLT. This correlation is

Table 1 (O-9).

	Recipient data	Donor Data	P
Age (y)	• 51.3 ± 11.5 (23% > 60y)	• 40.9 ± 13(29% > 50 y)	P < 0.001
Gender	• 57% men	• 59% men	NS
Features	• 72%: decompensated cirrhosis • 12%: fulminant hepatitis • 48%: Child-Pugh C • MELD at OLT: 20 ± 8.5 points • MELD > 22: 30%	• Height: 167.5 + 8.9 cm • 58%: cerebrovascular accident. • 38%: head trauma. • Mean DRI 1.4 • Ischemia time: 7.24 ± 0.09 h	

also true for R with a higher MELD score. The use of this score can be very helpful to allocate organs, considering also the R features and especially the regional distances to bring an organ without sacrificing the future allograft function.

O-10
REAL WORD DATA OF HCV TREATMENT WITH DIRECT ACTING ANTIVIRALS FROM THE LATIN AMERICAN LIVER RESEARCH EDUCATIONAL AND AWARENESS NETWORK (LALREAN)

RIDRUEJO E,[1,2] MENDIZÁBAL M,[2] HUGO C,[3] ANDERS M,[4] AMEIGEIRAS B,[5] REGGIARDO MV,[6] ALONSO C,[2] VARÓN A,[7] VIDELA ZUAIN MG,[8] SCHINONI MI,[9] ADROVER R,[10] MARCELO SILVA M,[2] ON BEHALF OF LATIN AMERICAN LIVER RESEARCH EDUCATIONAL AND AWARENESS NETWORK (LALREAN)

[1] HEPATOLOGY SECTION, DEPARTMENT OF MEDICINE. CENTRO DE EDUCACIÓN MÉDICA E INVESTIGACIONES CLÍNICAS NORBERTO QUIRNO "CEMIC". CIUDAD AUTÓNOMA DE BUENOS AIRES, ARGENTINA.
[2] HEPATOLOGY AND LIVER TRANSPLANT UNIT. HOSPITAL UNIVERSITARIO AUSTRAL. PRESIDENTE DERQUI, BUENOS AIRES; ARGENTINA.
[3] GASTROENTEROLOGY AND HEPATOLOGY DIVISION, HOSPITAL DE CLÍNICAS DE PORTO ALEGRE, PORTO ALEGRE, BRAZIL.
[4] HEPATOLOGY AND LIVER TRANSPLANT UNIT. HOSPITAL ALEMÁN. CIUDAD AUTÓNOMA DE BUENOS AIRES, ARGENTINA.
[5] GASTROENTEROLOGY AND HEPATOLOGY DIVISION, HOSPITAL RAMOS MEJÍA, CIUDAD AUTÓNOMA DE BUENOS AIRES, ARGENTINA.
[6] GASTROENTEROLOGY AND HEPATOLOGY DIVISION, HOSPITAL CENTENARIO, ROSARIO, ARGENTINA.
[7] FUNDACIÓN CARDIOINFANTIL, INSTITUTO DE CARDIOLOGÍA, BOGOTÁ, COLOMBIA.
[8] HEPATOLOGY UNIT. OSECAC. CIUDAD AUTÓNOMA DE BUENOS AIRES, ARGENTINA.
[9] FEDERAL UNIVERSITY. BAHIA, BRAZIL.
[10] CENTRO DE HEPATOLOGÍA. LA PALTA, ARGENTINA.

Background. Real word data evaluating the effectiveness of direct acting antivirals (DAAs) in HCV treatment had been reported from different regions. Our aim was to evaluate the effectiveness of DAAs treatment in routine clinical practice in Latin America. **Material and methods.** A prospective multicenter cohort from the Latin American Liver Research Educational and Awareness Network (LALREAN) was analyzed. We included patients who received DAAs according to international guidelines from January to April 2018 including: Sofosbuvir + Daclatasvir (SOF/DCV), Sofosbuvir + Simeprevir (SOF/DCV), Sofosbuvir + Ribavirin (SOF/RBV), Paritaprevir/Ritonavir/Ombitasvir/Dasabuvir (PROD), Ledipasvir + Sofosbuvir (LDV/SOF), Elbasvir/Grazoprevir (EBR/GZR), Sofosbuvir + Velpatasvir (SOF/VEL) and Asunaprevir + Daclatasvir (ASV/DCV). **Results.** From a total of 1,749 patients included in the database, 1,643 initiated treatment, and 1,313 underwent 12 weeks post-treatment evaluation and were included in the analysis. Baseline characteristics and outcomes are presented in the Table 1. Overall SVR 12 rate was 95.7%. SVR 12 rate was 96.5% in patients with cirrhosis, and 93.63% in patients with decompensated cirrhosis (MELD 13.1 ± 3.61; CPS score 7.95 ± 1.1). SVR 12 rate was 95.94% in patients treated with SOF/DCV and 96.13% with PROD. During post-SVR12 follow-up

Table 1 (O-10). Baseline characteristics and main outcomes.

	DDAs (n=1313)
Male sex (%)	56
Age (mean, yrs)	59.47 (SD 12.05)
Fibrosis stage 1,2,3,4 (%)	15/9/16/60
Cirrhosis Child Pugh Score	
A (%)	84
B (%)	13
C (%)	3
In liver transplant waiting list (n)	61
GT1,1a,1b,2, 3,4 (%)	7/26/38/8/20/1
HIV coinfection (%)	10.2
Liver transplanted patients (%)	7.53
Previous non responders (%)	44.36
DAAs	
SOF/DCV (%)	76.98 (1011)
LDV/SOF (%)	< 1 (13)
ASV/DCV (%)	1.6 (21)
SOF/SIM (%)	< 1 (7)
PROD (%)	14.25 (187)
EBR/GZR (%)	< 1 (8)
SOF/RBV (%)	4.95 (65)
SOF/VEL (%)	< 1 (1)
With RBV (%)	38.4
Overall SVR12, (%)	95.66
SVR12, GT1,1a,1b,2, 3,4 (%)	95.83, 94.78, 95.32, 95.37, 95.86, 92.87
Any adverse event (%)	27.89

10 patients died: 6 from non-liver and 4 from liver-related causes: 2 with HCC and 2 from progressive liver failure; 9 patients required a liver transplant and 31 developed a de novo HCC. In the latter groups of patients, 8 of 10 who had died, 8 of 9 requiring a liver transplant and 28 of 31 developing a de novo HCC achieved SVR 12. During post-SVR12 follow-up 23 patients (1.7%) developed cirrhosis decompensation. Thirteen patients (1 %) discontinued treatment before achieving the established treatment duration due to intolerance, 2 patients achieved SVR12; and 3 were lost from follow up. **Conclusion.** In a real life cohort in Latin America including patients with compensated and decompensated cirrhosis, treatment experienced and unfavorable genotypes, DAAs treatment was safe and achieved high SVR 12 rates. Sponsors of LALREAN: Bristol-Meier Squibb, Merck Sharp & Dohme, and Abbvie. **Acknowledgments.** Santos L, Fernández N, Palazzo A, Piñero F, Cocozzella D, Soza A, Tanno FC, Vistarini C, Zerega A, Borzi S, Figueroa S, Bruno A, Descalzi V, Hernández N, Estepo C, Garrocho Machado C, Gadea C, Sixto M, Barreyro F, Ratusnu N, Ceballos S, Pérez D, Mendoza C, Mengarelli S, Carbonetti R, Manero E, Moreno V, Tanno M, Ruf A, Caballini P, Romero G, Villa M, Billordo A on behalf of Latin American Liver Research Educational and Awareness Network (LALREAN).