identified in 37 participants (26.1%). The proportion of obese or overweight individuals (73% vs. 56%), diabetes mellitus (65% vs. 38%), dyslipidemia (65% vs. 50%), and MS (65% vs. 39%) was higher in the group with hepatic steatosis compared to those without. In multivariate analysis, hypertriglyceridemia (OR=2.80, 95%CI 1.22-6.43, p=0.015) and NODALT (OR=2.65, 95%CI 1.15-6.10, p=0.022) were identified as risk factors for NAFLD. NODALT occurred in 44 individuals (31%) and was associated with time from LT (OR=1.009, 95%CI 1.003-1.015, p=0.004), current body mass index (OR=1.105, 95%CI 1.014-1.204, p=0.022), and fatty liver (OR=2.832, 95%CI 1.082-7.415, p=0.034). Prevalence of advanced chronic liver disease, according to elastography, was 11%. The concordance between non-invasive scores and 2D-SWE was very low, with only 38% for FIB4 and 31% for NFS when elastography indicated advanced fibrosis and 25% and 20% for FIB4 and NFS, respectively, when elastography indicated the absence of advanced fibrosis.

Conclusions: NAFLD, liver fibrosis and NODALT are common after LT. There is a need for improved non-invasive methods to accurately identify advanced fibrosis in LT patients.

https://doi.org/10.1016/j.aohep.2023.101194

P-8 OSTEOSARCOPENIA AND FIBROSIS SEVERITY IN NON-ALCOHOLIC FATTY LIVER DISEASE

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Introduction and Objectives: Both osteosarcopenia and non-alcoholic fatty liver disease (NAFLD) are subject to complex and interconnected pathophysiological processes. This study aimed to assess the osteosarcopenia frequency in NAFLD and its association with liver fibrosis.

Materials and Methods: Adults with established risk factors for the development of NAFLD were selected. Assessment of NAFLD and degrees of fibrosis was performed by ultrasound (US-FLI) and ultrasound elastography. Quantitative assessment of muscle mass and bone mass density (BMD) were measured with dual energy X-ray absorptiometry (DXA). Low BMD was defined as established by WHO. Appendicular lean mass (ALM), representing the sum of lean mass at upper and lower limbs; appendicular lean mass index (ALMI: ALM/height2). Sarcopenia if ALMI <7.0 kg/m2 men or <5.5 kg/m2 women.

Results: 73 participants were enrolled, and hepatic steatosis was present in 58. All data are presented as median (IQR) or n (%). Age 63 (53-67) years, women 59(80.8%), 25(OH)D3 levels 26(22-31) ng/mL. The frequency of liver fibrosis (F 2), low levels of vitamin D (<20 ng/mL) and sarcopenia was, respectively: 16(22%), 14 (19%), 6(8%). We found low BMD in 43 (59%), of these 6(14%) osteoporosis, 35(81.4%) osteopenia and 2(4.6%) low BMD for age. The groups with and without fibrosis did not show differences in the levels or frequency of vitamin D deficiency or sarcopenia. However, participants with fibrosis had lower T-score and lower BMD in the lumbar spine and hip when compared to participants without fibrosis, p<0.05.

Conclusions: Our data suggest that the frequency of low BMD is higher in the population with NAFLD and high incidence of liver fibrosis than in the general Brazilian population. Evaluating by DXA, we observed that patients with liver fibrosis have lower bone mass, but not less muscle mass compared to patients without fibrosis.

https://doi.org/10.1016/j.aohep.2023.101195

P-9 AUTOIMMUNE LIVER DISEASES IN LATIN AMERICA: A WEB-BASED SURVEY

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Introduction and Objectives: Autoimmune liver diseases (AILD), including autoimmune hepatitis (AIH), primary biliary cholangitis (PBC), and primary sclerosing cholangitis (PSC), are chronic immune-mediated liver conditions. This study aimed to assess the reality of AILD in Latin America (LA).

Materials and Methods: A web-based survey consisting of 35 questions on AILD was distributed to hepatologists affiliated with ALEH through social media.

Results: A total of 65 hepatologists participated in the survey. The most treated AILD in the region was AIH. Widely available antibodies for diagnosis included anti-mitochondrial (100%), anti-smooth muscle (98.5%), and anti-nuclear antibodies (95.4%), while access to anti-gp210/sp100 antibodies was limited (<55%). Although 97% had access to liver biopsy, only 72.3% were assisted by liver pathologists. Elastography and endoscopic retrograde cholangiopancreatography were available for 90.8% and 98.5%, respectively. Ursodeoxycholic acid (UDCA) was the primary medication for PBC (100%), followed by fibrates (bezafibrate: 56.3%, fenofibrate: 71.9%). There was considerable heterogeneity in selecting the criteria to evaluate PBC response to UDCA, with 39.3% favoring Paris II criteria. Cholestyramine/antihistamines were commonly recommended for treating pruritus, while fibrates were used by only 47.7%. For PSC, 86.2% of hepatologists indicated the use of UDCA. Azathioprine was the main immunosuppressor employed for AIH treatment, although indications for treatment were controversial. Most physicians treated patients with signs of active disease, regardless of liver enzyme and IgG levels. Prednisone alone was the primary treatment recommended for AIH patients with decompensated cirrhosis (70.7%). Remission in AIH was mostly defined by normalization of liver enzymes and IgG with minimal/absent inflammation on histology (47.7%), with only 60% of respondents performing liver biopsies to assess histological remission. While 62.5% of the participants attempted to withdraw AIH treatment, 78% refrained from discontinuing treatment in the presence of anti-SLA.

Conclusions: This survey provides valuable insights into the current management of AILD in LA, highlighting areas of heterogeneity that warrant further investigation.

https://doi.org/10.1016/j.aohep.2023.101196

P-10 THE EFFECTS OF CHILEAN RESPONSE TO COVID-19 ON ALCOHOL CONSUMERS: A NATURAL POLICY EXPERIMENT

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