Methods Retrospective study by data gathering from hepatitis clinic, Hatyai hospital during 2014–2017. Statistical analysis: Chi-square test

Inclusion criteria 1. Anti-HCV positive with detectable viral load 2. Measure CAP pre treatment

Exclusion criteria 1. Loss follows up 2. No result of HCV RNA viral load post treatment

Results Seventy-four HCV infected patients participate in the study. 25.42% of the participants were hepatic steatosis (n=15). SVR in hepatic steatosis group were 80% VS SVR in without hepatic steatosis group were 71.19% (P=0.75).

Conclusions No relationship between hepatic steatosis by using CAP and result of HCV treatment

IDDF2019-ABS-0123 PRE-ENDOSCOPY SCREENING FOR HEPATITIS VIRUSES IN UNDER-DEVELOPED AND DEVELOPING COUNTRIES: HOW USEFUL IS IT?

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Background Data regarding the transmission of viral infectious agents via gastrointestinal endoscopes is not available from low-income countries. We aimed to determine the prevalence of HBV and HCV infections in patients underwent upper GI endoscopy (UGIE) in a public sector hospital.

Methods In a cross-sectional study, all consecutive patients undergoing UGIE were screened for hepatitis B and C infection (immunochemical assays). Prevalence of HBV and HCV infection in patients underwent UGIE were calculated before and after exclusion of already diagnosed cases of chronic liver disease (CLD).

Results A total of 2,686 patients were screened and 2,499 were enrolled in the study. The mean age of patients was 42.6 (±16.3) years (M: F=1.9:1). Out of 2,499 patients, 221(8.8%) were tested positive for HBsAg. Among them, 123 (55.6%) were previously diagnosed HBV-related CLD cases and 98 (44.3%) were newly diagnosed cases. Past history of blood transfusion, surgery and jaundice were present in 4.5%, 14.4% and 24.4% patients, respectively. Risk factors were unidentified in 57% of patients. Out of 2,499, 36 (1.4%) patients were tested positive for anti-HCV antibody. Among them, 19 (52.7%) were previously diagnosed HCV-related CLD cases and 17 (47.2%) were newly diagnosed cases. Past history of blood transfusion,

surgery and jaundice were present in 44.4%, 52.7% and 16.6% patients, respectively. Risk factors were unidentified in 27.7% of patients. In this study, nearly half of the patients were newly diagnosed cases of HBV and HCV infections. Identifiable risk factors were absent in 57% and 27.7% of HBV and HCV infected patients, respectively. Hence, just a negative history was not sufficient to rule out these infections prior to a GIE.

Conclusions Many of the endoscopy units of public sector hospitals of under-developed and developing countries is overburdened, understaffed, and under-equipped. Proper disinfection/sterilization of endoscopes and accessories is sometimes questionable because of inadequate infrastructures. Therefore, it may be beneficial to include a determination of hepatitis serology of patients prior to endoscopy. However, the cost of pre-screening tests is the major problem for routine screening. Hence, the screening may be recommended for high-risk patients only.

IDDF2019-ABS-0131 ALGORITHMS USING NONINVASIVE TESTS CAN ACCURATELY IDENTIFY PATIENTS WITH ADVANCED FIBROSIS DUE TO NASH: DATA FROM THE STELLAR CLINICAL TRIALS

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Background There is a major unmet need for accurate, readily available, noninvasive tests (NITs) to identify patients with advanced fibrosis due to NASH. Our goal was to evaluate

Abstract IDDF2019-ABS-0131 Table 1 Diagnostic performance of nits to discriminate advanced fibrosis f3-f4

Test*	Cohort	Sample Size	Sensitivity	Specificity	Indeterminate	Misclassified**
FIB-4 (1.23, 2.1)	Train+Test	2496	85%	85%	32%	15%
	Validation	627	83%	89%	32%	15%
ELF (9.35, 10.24)	Train+Test	2536	85%	85%	29%	15%
	Validation	637	85%	85%	29%	15%
FS (9.6kPa, 14.53kPa)	Train+Test	1408	85%	86%	28%	15%
	Validation	357	82%	88%	25%	17%
FIB-4 (1.23, 2.1) then ELF (9.35, 10.24)	Train+Test	2542	79%	81%	13%	20%
	Validation	638	78%	82%	13%	21%
FIB-4 (1.23, 2.1) then FS (9.6kPa, 14.53kPa)	Train+Test	2509	82%	85%	20%	17%
	Validation	632	78%	87%	20%	19%

*Lower value represents optimal threshold to exclude advanced fibrosis, higher value to diagnose advanced fibrosis, with in-between values classified as indeterminate

**Proportion of misclassified patients relative to total sample size including indeterminate zone