The median follow-up time was 37.5±1.2 months for HAP A, 40.8±2.9 months for HAP B, 24.0±2.5 months for HAP C and 20.4±4.1 months for HAP D. There were no deaths at the first year in HAP A. The cumulative proportion surviving at first years for HAP B, C, D was 97.4; 77.9 and 66.7, respectively. At 36 months, this percentage for HAP A, B, C and D was 92.3; 72.5; 31.1 and 27.1, respectively, (IDDF2021-ABS-0070 Table 2). Survival of all subgroups differed significantly from each other (each p < 0.05) (IDDF2021-ABS-0070 Figure 2. Kaplan-Meier curve for HAP score). Area under the curve for receiver operating characteristic of HAP score was 0.71 and higher than this of ALBI grade (0.57) (IDDF2021-ABS-0070 Figure 3. ROC curves for HAP score and ALBI grade), indicating a significant performance of HAP score compared with ALBI grade in prognosis of HCC treated with TACE.

Conclusions HAP is a useful score to assist for the management decisions of patients with HCC requiring TACE due to its value in predicting mortality and survival.

Background Tumor size and numbers are major determinants of tumor burden in hepatocellular carcinoma (HCC). Patients with HCC undergoing transarterial chemoembolization (TACE) have variables outcomes due to heterogeneity of tumor burden. Recently, tumor burden score (TBS) was proposed to evaluate the extent of tumor involvement. However, the prognostic accuracy of TBS has not been evaluated in HCC. This study aimed to assess its prognostic role in HCC patients undergoing TACE.

Methods A total of 935 treatment-naive HCC patients receiving TACE were retrospectively analyzed. Multivariate Cox proportional hazard model was used to determine independent prognostic predictors. TBS was defined as the distance from the origin of the Cartesian plane and the comparison of two variables: maximum tumor size (X-axis) and number of tumors (Y-axis) so that $TBS^2 = (\text{maximum tumor diameter})^2 + (\text{number of tumors})^2$. Patients have divided accordingly into three groups: high TBS (over 13.74), medium TBS (3.36-13.74), and low TBS (less than 3.36).

Results TBS tended to increase with the increasing size and number of tumors in this study (IDDF2021-ABS-0071 Figure 1. The association of TBS with tumor diameter and numbers). The Cox model showed that serum creatinine/C21/1.2mg/dl (hazard ratio (HR): 1.296, 95% confidence interval (CI): 1.077-1.559, p=0.006), serum alpha-fetoprotein/C21/400ng/dl (HR: 2.245, 95% CI: 1.905-2.465, p<0.001), vascular invasion (HR: 1.870, 95% CI: 1.520-2.301, p<0.001), medium TBS (HR: 1.489, 95% CI: 1.206-1.839, p<0.001), high TBS (HR: 2.563, 95% CI: 1.823-3.602, p<0.001), albumin-bilirubin (ALBI) grade 2-3 (HR: 1.521, 95% CI: 1.291-1.792, p<0.001),
Efficacy and safety of tenofovir alafenamide (TAF) vs tenofovir disoproxil fumarate (TDF) in East Asian chronic hepatitis B patients following 5 years of treatment

Grace Lai Hung Wong*, 1 Edward Gane, 1 Calvin Pan, 2 Young-Suk Lim, 3 Scott Fung, 4 Namiki Izumi, 5 Mang Ma, 6 Carol Yee Kwan Chan, 7 Dr Shalimar, 8 Maria Buti, 9
1Department of Medicine and Therapeutics, The Chinese University of Hong Kong, Hong Kong; 2Department of Medicine, University of Auckland, Auckland, New Zealand; 3Division of Gastroenterology and Hepatology, Department of Medicine, NYU Langone Medical Center, NYU School of Medicine, New York, USA; 4Department of Gastroenterology, Asan Medical Center, University of Ulsan College of Medicine, Sanga-ku, Seoul, Korea, South; 5Toronto Centre for Liver Disease, Toronto General Hospital, University Health Network, Toronto, Ontario, Canada; 6Department of Gastroenterology, Musashino Red Cross Hospital, Tokyo, Japan; 7Division of Gastroenterology (Liver Unit), University of Alberta, Edmonton, Canada; 8Gilead Sciences, Foster City, CA, USA; 9Department of Gastroenterology and Human Nutrition, All India Institute of Medical Sciences, New Delhi, India; 10Liver Unit, Vall d’Hebron Hospital, Hospital General Universitario Valle Hebron and Ciberehd, Barcelona, Spain

Background Pivotal studies GS-US-320-0108 (HBeAg-negative) and GS-US-320-0110 (HBeAg-positive), demonstrated non-inferior antiviral efficacy of TAF vs TDF with superior renal/bone safety through 5 years, after up to 3 years of double-blind (DB) treatment, open-label (OL) TAF was available through year 8. We analyzed TAF efficacy and safety among patients of Asian Ethnicity in Studies 108/110.

Methods Efficacy was assessed by individual study and included virologic, biochemical, and serologic assessments. Safety data were pooled including estimated GFR (by Cockcroft-Gault method; eGFRCG) and hip and spine bone mineral density (BMD) changes.

Results Among 1298 patients randomized and treated, 591 (45.5%) were Asian (TAF n=410, while n=84 and n=106 received TDF-OL-TAF-3 years and TDF-OL-TAF-2 years, respectively. Virologic control was achieved and maintained in patients receiving TAF (95%) and for TDF-OL-TAF-3 years (100%) and TDF-OL-TAF-2 years (98%). ALT normalization rates were comparable among groups (TAF: 79%, TDF-OL-TAF-3 years: 80%; TDF-OL-TAF-2 years: 79%). HBeAg loss/seroconversion was similar (TAF: 38.6%/27.4%, TDF-OL-TAF-3 years: 46.9%/37.5%; TDF-OL-TAF-2 years: 47.1%/29.4%). Rates of HBeAg loss/seroconversion were similar in all groups (≤1%). Rates of Grade ≥3 adverse events (AEs) and AEs leading to discontinuation were low (1.5%) among all groups. After experiencing declines in eGFRCG in hip/spine BMD over 2 or 3 years of TDF treatment, renal and bone outcomes were improved following the switch to OL TAF.

Conclusions After 5 years of treatment, virologic suppression remained high, and TAF was safe and well-tolerated with improved renal and bone safety among patients of Asian Ethnicity switching from TDF.