Background Study 4018, an international Phase 3 study, previously demonstrated switching to tenofovir alafenamide (TAF) vs continued tenofovir disoproxil fumarate (TDF) in suppressed chronic hepatitis B (CHB) patients has non-inferior efficacy (TAF vs TDF) with superior bone/renal safety. We analysed the efficacy and safety of switching in Asian Ethnicity (AE) patients in Study 4018.

Methods CHB patients on TDF for ≥ 48 weeks with HBV DNA less than LLOQ for ≥ 20 IU/ml at screening were randomized to TAF 25mg QD or TDF 300mg QD, each with a matching placebo, and treated for 48 weeks in a double-blind (DB) fashion followed by all patients receiving open-label (OL) TAF 25 mg QD for an additional 48 weeks.

Results 400/488 (82%) were AE patients who received at least 1 dose of study drug, with 195 in the TAF-TAF arm and 205 in the TDF-TAF arm. Virologic suppression was similarly maintained at 96-wk in both groups (95%: TAF and 94% TDF). Higher percent changes in BMD from baseline (both hip and spine) were seen among the TAF-TAF group [1.2 (3.0 SD) for hip and 2.5 (4.0) SD for spine] vs TDF-TAF group [0.12 (2.8 SD) for hip and 1.5 (3.8) SD for spine]. eGFR_{CG} increased over years in the TAF-TAF group and from Week 48 to 96 in the TDF-TAF group. There were no study drug-related treatment-emergent grade 3 or 4 AEs or SAEs.

Conclusions Following TDF to TAF switch, viral suppression was maintained, with improved bone and renal safety parameters through 96 weeks in AE patients.

IDDF2021-ABS-0083 ASSESSMENT PRE- AND POST-TREATMENT QUALITY OF LIFE BY EORTC QLQ-C30 QUESTIONNAIRE IN PATIENTS WITH HEPATOCELLULAR CARCINOMA AT HANOI MEDICAL UNIVERSITY, VIETNAM

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Background To assess the quality of life (QoL) of patients with hepatocellular carcinoma (HCC) by the European Organization for the Research and Treatment of Cancer quality of life questionnaire (EORTC QLQ-C30).

Methods A prospective study was conducted from August 2020 to August 2021. We evaluated the QoL of 30 patients diagnosed of HCC at Bach Mai and Hanoi Medical University Hospital after a month of treatment. EORTC-QLQ C30 items were converted to scores according to an available formula, the total score for each section ranged from 0 to 100. A low functional score reflected a low QoL, while a lower symptom score indicated a higher QoL. The overall EORTC score (C30 index score) would be calculated according to the available formula. The lower the C30 index score was, the better the QoL would be.

Results The C30 index before transarterial chemoembolization (TACE) assessed by the EORTC QLQ-C30 questionnaire was 27.344 ± 10.15 and that after TACE was 19.63 ± 11.3 ; the difference was statistically significant with p value < 0.0001 . The pre-and post-TACE overall EORTC QLQ-C30 score, the functional and symptoms score had a statistically significant difference (p value < 0.05). The QoL score had a positive correlation with the degree of liver failure according

to Child-Pugh classifications and ECOG PS grade with rho index of 0.401 ($p = 0.028 < 0.05$) and 0.682 ($p < 0.001$), respectively. The EORTC QLQ-C30 questionnaire was useful in assessing the QoL of HCC patients with pre-and post-treatment Cronbach's alpha scores of 0.816 and 0.920, respectively.

Conclusions The EORTC QLQ-C30 questionnaire was a useful scale in evaluating the pre-and post-treatment quality of life in patients with HCC, which correlates with the patient's physical condition and liver function.

IDDF2021-ABS-0084 TUBERCULOSIS AS A COMMON CAUSE OF POST-LIVER TRANSPLANT ASCITES

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Background Refractory ascites due to cirrhosis is one of the common indications for liver transplant (LT). Ascites are expected to resolve within 2-4 weeks following orthotopic liver transplant as the reversal of hemodynamic changes occurs by then. New-onset ascites after transplant has varied causes. The most common causes for the development of ascites after LT are hepatic inflow or outflow obstructions, hepatitis C, graft rejection, prolonged cold ischemia time. In addition, extrahepatic causes like infections, chronic kidney diseases, or heart failure can lead to ascites.

Methods In this retrospective study, we aimed to assess the incidence and causes of ascites in post-transplant patients during the last year.

Results A total of 95 patients underwent living donor liver transplantation (LDLT) in our institution. Seven out of 95 developed ascites post-liver transplant. The mean age of patients was 46 ± 18.98 years. 57% of patients were females. The indication of LDLT was decompensated cirrhosis in all patients. Three underwent LDLT for AUD-related liver disease, one each for NASH, chronic hepatitis B, Budd-Chiari syndrome, and Wilson disease. The mean time to ascites onset was 2.9 months. All the patients had ascites prior to liver transplant, out of which 5 (71%) had refractory ascites. 5 (71%) had HRS prior to transplant. Cold ischemia time was 98 ± 19 min (IDDF2021-ABS-0084 Table 1). Five patients were diagnosed with tubercular ascites, one had tacrolimus-related proteinuria and ascites formation, and one more patient developed IgA nephropathy causing significant proteinuria and ascites. None of the patients had concomitant pulmonary tuberculosis. Rifampicin, levofloxacin, and ethambutol were initiated with a gradual introduction of isoniazid over the next 15 days. One of the patients developed ATT-induced liver injury and graft dysfunction after switching from rifampicin to rifabutin. He was treated with N-acetylcysteine and had delayed recovery with conservative management.

Conclusions Tuberculosis is a common cause of post-transplant ascites. Although global data suggest vascular etiologies as a common cause of persistent ascites post-transplant, in the Indian scenario, tuberculosis should always be considered as a differential diagnosis while evaluating these patients. Being a potentially curable cause, it significantly improves graft survival after treatment.