(95% CI: 3.8–54.0), p = 0.0001 and alcoholic etiology-OR = 5.3 (95% CI: 1.1–26.3), p = 0.03.

	Spearman r correlation coefficient
Age	r = 0.089, p = 0.30
Male gender	r = 0.052, p = 0.54
BMI	r = 0.103, p = 0.23
Alcoholic etiology	**r = 0.186, p = 0.03**
Spleen size	r = 0.082, p = 0.34
Presence of CCM	**r = 0.323, p = 0.0001**
Child-Pugh score	**r = 0.259, p = 0.002**
MELD score	**r = 0.237, p = 0.005**
Presence of portal hypertension	r = 0.107, p = 0.21
Albumin	r = –0.169, p = 0.06
Platelet count	r = 0.037, p = 0.67
Prothrombin time	**r = –0.197, p = 0.02**

Conclusion: The presence of CCM is a strong predictor of acute kidney injury development among cirrhotic patients.

Non-invasive assessment of liver disease except NAFLD

OS013

Association of long term methotrexate therapy with liver fibrosis markers: a multi-centre prospective case-control study

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Background and aims: Incidence of acute drug-induced liver injury due to methotrexate (MTX) reduces significantly after the first year of treatment. However, decompensated cirrhosis attributed to MTX accounts for 0.07% of patients listed/transplanted in the USA. We evaluated the risk of long-term MTX therapy on liver fibrosis prospectively in a case-control study.
Method: Between 2014–2021, adult patients diagnosed with Rheumatoid Arthritis (RA) or Psoriasis (PS) were recruited prospectively from six UK sites. Patients on MTX for ≥6 months were defined as cases, whereas those with RA or PS for ≥2 years who never received MTX were controls. All patients underwent full liver profile, enhanced liver fibrosis (ELF) markers, and transient elastography (TE). Multivariate analysis was performed using logistic regression and results were presented as adjusted odds ratio (OR) and 95% confidence interval.
Results: Of 999 patients included (mean age 60.8 ± 12 years, 622 females (62.3%)), 976 had valid TE values; 149 (15.3%) had liver stiffness ≥7.9 KPa. Of 892 with available ELF, 262 had ELF score ≥9.8 (29.4%). Age and BMI were independently associated with elevated liver stiffness and ELF. Diabetes was associated with significant fibrosis defined by liver stiffness ≥7.9 KPa, OR = 3.21 (1.96–5.21), p < 0.001. But, neither MTX cumulative dose nor duration of exposure was associated with elevated liver stiffness [OR = 1.02 (0.93–1.12) and 1.00 (0.99–1.0), respectively] and ELF score [OR = 1.06 (1.0–1.12) and 1.00 (0.99–1.0), respectively]. Regular use of non-steroidal anti-inflammatory drugs was associated with ELF score ≥9.8, OR = 1.78 (1.22–2.60), p = 0.003.
Conclusion: Lack of association of MTX cumulative dose and duration with liver fibrosis in RA or PS indicates that the risk of liver fibrosis due to MTX itself might have been overestimated. The degree of inflammation in RA and PS may confound ELF as a marker to detect fibrosis.

Table: Demographic and phenotypic features for cases and controls

Characteristics	MTX group (n = 876)	Control group (n = 123)	p
Age (years), mean (SD)	61.6 (11.6)	55.6 (13.5)	**<0.001**
Female, n (%)	560 (63.9)	62 (50.4)	**<0.01**
Diagnosis, n (%)		55 (44.7)	**<0.001**
RA	615 (70.2)	67 (54.5)	
PS	241 (27.5)	1 (0.8)	
Both	20 (2.3)		
Type 2 Diabetes	100 (11.5)	21 (17.1)	**NS**
Hyperlipidaemia	225 (25.9)	28 (22.8)	**NS**
BMI (kg/m^2), mean (SD)	29.9 (6.7)	30.9 (7.5)	**NS**
Alcohol >14 units/week, n (%)	83 (9.5)	25 (20.3)	**<0.001**
Fibrosis markers			
TE groups, n (%)	731 (85.5)	96 (79.3)	**0.08**
Low <7.9	124 (14.5)	25 (20.7)	
High ≥ 7.9			
ELF groups, n (%)	562 (71.4)	68 (64.8)	**NS**
Low risk <9.8	202 (25.7)	34 (32.4)	
Moderate risk (≥9.8 to <11.3)	23 (2.9)	3 (2.9)	
High risk ≥11.3			

NS: Not significant.

OS014

Development and validation of a machine learning-based model for varices screening in compensated cirrhosis (CHESS2001): an international multicenter study

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