

HCV GENOTYPE 4 IN BELGIUM : EPIDEMIOLOGICAL CHARACTERISTICS. C. Reenaers (1), J. Delwaide (1), C. Gerard (1), B. Bastens (2), B. Servais (3), A. Bekhti (4), E. Wain (5), G. Daenen (1), M. Delforge (2), T. Mesureur (1), B. Sente (6), + GLEVHE (7), J. Belaiche (1), A. De Roover (8), O. Detry (8), P. Honoré (8), M. Meurisse (8), B. Rentier (9), D. Vaira (9). (1)CHU Sart Tilman ; (2) St.Joseph Liège ; (3) Bois Abbaye Liège ; (4) Liège ; (5) La Tourelle Verviers ; (6) Waremme ; (7) Groupe Liégeois Etude Virus Hépatotropes ; (8) CHU Sart Tilman Chirurgie ; (9) CHU Sart Tilman Virologie.

In Western countries, patients (pts) infected with HCV genotype 4 are uncommon (5%) and are thought to be mostly from African origin. The higher prevalence of genotype 4 observed in Liège (11%) is thought to be related to the African immigration.

Aim of the study : to determine the genotype 4 patients' characteristics in our area.

Method : The files of 42 HCV genotype 4 pts were reviewed.

Results : Mean age was 42 ± 13 , with 55% females. Nineteen pts (45%) were from European origin without history of travel in Africa. In African pts, main modes of transmission were transfusion (26%), and infection of undetermined origin (70%). No IV drug users were found. In the opposite, among Europeans, IV drug users were found in 42%, and contamination of undetermined origin in 42%, while no contaminations by transfusion were observed. Subtypes 4a (4pts), 4e (4pts), and 4f (1pt) were exclusively encountered in Africans, while the 2 pts with subtype 4c were Europeans. Subtypes 4c/4d (17pts) and 4h (11 pts) were found both in Africans and in Europeans (4c/4d : Europeans 65% ; 4h : Europeans 46%). Among Europeans pts for whom mode of transmission was undetermined, half was originating from Italy or Portugal. A treatment with interferon (IFN) and ribavirin was given in 15 pts. The rate of sustained viral response (SVR) was 13%.

Conclusions : In our area, nearly half of genotype 4 pts are Europeans. In European pts, IV drug use was an important mode of transmission, as well as transmission of undetermined (sporadic) origin, while no contaminations with transfusion were found. The sporadic contaminations in Europeans seem to have occurred mainly in pts originating from Italy and Portugal. Treatment with conventional IFN and ribavirin gave a low rate of SVR.

CADAVERIC OR LIVING RELATED LIVER TRANSPLANTATION FOR HEPATOCELLULAR CARCINOMA : IS EXTENSION OF THE MILAN CRITERIA DELETERIOUS FOR TUMOUR FREE SURVIVAL? H. Van Vlierberghe (1), R. Troisi (2), I. Colle (1), M. Praet (3), B. de Hemptinne (2). (1) Dpt of Gastroenterology and Hepatology, (2) Dpt of Hepatobiliary Surgery and Liver Transplantation, (3)Dpt of Pathology, Ghent University Hospital.

Introduction : In patients with hepatocellular carcinoma (HCC) receiving a liver transplant, outcome is better if the number of lesions is low (equal or less than 3) and the size of the tumour is small (less than 5 cm in patients with a single tumour, less than 3 cm in patients having more tumours) (Milan criteria). Recently however more data are questioning these strict criteria and suggesting expansion of these criteria without compromising outcome. Prospective randomised trials are difficult to perform in this setting. However since living related liver transplantation (LRLTx), after informed consent of donor and recipient, can be performed in patients outside the Milan criteria, we compared outcome of liver transplantation for HCC between LRLTx and cadaveric liver transplantation (CLTx).

Materials and methods : In a retrospective way, outcome was compared between HCC patients receiving a LRLTx and CLTx. The Milan criteria were, as is clinically done, measured prior to transplantation. In patients outside the Milan criteria a LRLTx was more often proposed since, in the absence of clear data, we preferred not to compromise the cadaveric organ pool. Log rank testing and Kaplan Meier survival curves were used to test statistical significance.

Results : Patients (n=32) transplanted for a HCC between 6/1999 and 6/2002 were included (14 CLTx/18 LRLTx). Patients receiving a LRLTx were younger than CLTx patients (54 year \pm 5 versus 59 year \pm 6, $p=0.02$). LRLTx patients were more often outside the Milan criteria than CLTx patients (8/18 versus 2/14, $p=0.15$). There was no difference in follow up time between LRLTx and CLTx (665 days \pm 530 versus 532 days \pm 327, $p=NS$). Survival and HCC free survival were not different between the LRLTx and CLTx group (70 %). HCC free survival was significant lower for patients outside the Milan criteria than those within the criteria ($p=0.01$, fig). However patients outside the Milan criteria without vascular invasion had a similar outcome as patients within the criteria.

Discussion : Outcome in HCC patients receiving a CLTx or LRLTx was not different. When patients with vascular invasion are excluded, extension of the Milan criteria does not impair outcome after liver transplantation. However before implementing more liberal rules for HCC patients on the waiting list, more data are definitely needed.