Methods: Medical records from TTR-FAP adult patients submitted to liver transplant in a single center more than eight years ago were reviewed (until December 2006, 681 LT were performed, 179 by FAP; 125 patients are still alive, 28 of them with neurological syndrome de novo). All the patients were submitted to a thorough neurological workup, and almost all had normal exams. MRIs were not performed due to protocol cardiac pacemaker insertion prior to liver transplant.

Results: 28 patients (22%) developed the same transitory, sporadic "de novo" neurological symptoms such as generalized absence, drowsiness, headache, unilateral paresthesias, hemiparesis, aphasia, dysarthria, slurred speech, double vision, blurred vision, partial seizures and myoclonic, dizziness and vertigo syndrome, behavior changes and mental confusion. All patients are treated or have been in the past with calcineurin inhibitors (CNI), 26 with cyclosporine and 2 with tacrolimus; those in which CNI were suspended improved or remained without these symptoms. Antiepileptic drugs were prescribed with partial remission of the symptoms.

Conclusions: Neurological syndrome de novo have a significant impact on quality of life of these patients. These symptoms may be due to the natural progression of the disease apparently due to the increased survival of these patients with the LT. We must review the immunosuppression of these patients. Further studies are needed to improve treatment and quality of life of the transplanted TTR-FAP.

P0052
INFUSION OF THIRD-PARTY MESENCHYMAL STROMAL CELLS AFTER LIVER TRANSPLANTATION: A PHASE I, OPEN-LABEL, CLINICAL STUDY
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Background and Aims: Mesenchymal stromal cells (MSC) are multipotent bone marrow progenitors that have demonstrated significant immunosuppressive effects in various in vivo and in vitro studies. This study aimed to be the first evaluation of the safety and tolerability of MSC infusion after liver transplantation in a prospective, controlled phase-1 study.

Methods: Clinical grade MSCs were locally collected from the bone marrow of unrelated healthy donors. They were cultured in a GMP-compliant lab, underwent extensive quality controls and were frozen for storage in a MSC bank. When needed for patient treatment, MSC were thawed and intravenously injected into patients. 10 liver transplant recipients under standard immunosuppression (TAC-MMF-low dose steroids until day 30) received 1.5–3×10^6/kg MSC on post-operative day 3–2. These patients were prospectively compared to a group of 10 control (MSC-) liver recipients. Primary endpoints were MSC infusion toxicity, and incidence of cancer and opportunistic infections at month 6. Secondary endpoints were patient and graft survivals and rejection at month 6, as well as the effects of MSC on recipients' immune function and on immunohistology of at month 6 graft biopsies.

Results: No MSC infusional toxicity was observed. Both groups were comparable in terms of donor and recipient characteristics. There was no difference in primary end-points between control and MSC groups. No patient developed de novo cancer. There was no statistical difference in patient and graft survivals or in rejection rates. There was no graft rejection in the MSC group. Month-6 graft biopsies were not different according to Banff and fibrosis scores.

Conclusions: This phase 1 study showed excellent tolerability and safety of a single infusion of third-party MSC after liver transplantation. There were no graft safety issues and no excess of immunosuppression after MSC injection. Further analyses of consequences of MSC injection on the immune profile are needed. The possibility of avoiding calcineurin-inhibitors with repeated MSC injections as main immunosuppressive therapy and/or tolerance induction by MSC infusion should be investigated by further studies.

P0053
DISTINCT INTRAHEPATIC CYTOKINE PROFILES FOR THE DIFFERENTIATION OF ACUTE CELLULAR REJECTION VS RECURRENT HEPATITIS C IN LIVER TRANSPLANTED PATIENTS
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Background and Aims: Graft reinfection in liver transplanted patients with hepatitis C virus (HCV) infection is universal and triggers rejection episodes as well as liver damage and fibrosis. Reliable differentiation between HCV infection early after liver transplantation and acute cellular rejection (ACR) is of great importance for clinicians and poses a challenge for pathologists.