**Method:** All cDCD older than 70 years were evaluated during normothermic regional perfusion (NRP) and then randomly assigned to dual hypothermic (D-HOPE) or normothermic machine perfusion (NMP).
**Results:** In the period from April 2021 to December 2023, 25 cDCD older than 70 years were considered. In 9 cases (36%) the graft was not considered suitable for liver transplantation: 3 on NRP parameters, 2 on histology, 1 due to hepatic artery thrombosis at procurement, 2 on NMP parameters, and 1 due to machine perfusion technical failure. Sixteen (64%) liver grafts were eventually transplanted. The median donor age was 82 years (IQR: 79–84), being 9 (56%) older than 80. The mean functional warm ischemia was 39 ± 15 minutes. Grafts were randomly assigned to D-HOPE (9 grafts) and NMP (7 grafts). There were no cases of primary non-function, one of the patients (D-HOPE LT) experienced delayed non-function, treated with retransplantation. Four cases of post-reperfusion syndrome (25%, 50% D-HOPE vs 50% NMP group) and 2 cases (12%) of early allograft dysfunction were observed. At a median follow-up of 12 months, no vascular complications were reported. Three patients experienced biliary complications: 2 anastomotic stenosis and 1 biliary fistula. No patients experienced ischemic cholangiopathy. No major differences were found in terms of post-operative hospitalization or complications based on the type of machine perfusion.
**Conclusion:** The implementation of sequential normothermic regional and end-ischemic machine perfusion allows the safe use of very old DCD donor grafts in liver transplantation.

**SAT-014-YI**

**Bariatric surgery post-liver transplantation: a Belgian nationwide study**

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**Background and aims:** Weight gain and metabolic dysfunction-associated steatotic liver disease (MASLD) pose a rising graft concern post-liver transplantation (LT). Bariatric surgery (BS) can be considered for post-LT weight gain, although the literature is limited and the long-term outcome still uncertain. We previously reviewed the literature and concluded that timing is crucial when considering BS in a population with liver disease or transplantation. Our current aim was to describe the demographics, mortality, and effect of BS in a post-LT population.
**Method:** We conducted a national retrospective analysis in 5 Belgian transplant centres and included 25 patients with a liver transplantation between 1/1/2000 and 31/12/2018 followed by a bariatric procedure between 1/1/2005 and 31/12/2020. 187 LT patients without BS were included for comparison. Clinical, biochemical and outcome data were retrospectively retrieved. Statistical analysis was performed using the t-test, Mann-Whitney U, and Chi2 tests.
**Results:** In our nation-wide sample, 25 patients had undergone BS post-LT, at a median 3.5 (2.1, 5.6) years after LT. Twenty-one (84.0%) patients received a sleeve gastrectomy (SG), 3 (12.0%) a Roux-en-Y gastric bypass (RYGB) and 1 (4.0%) a one-anastomosis gastric bypass. All but one procedure (96.0%) were performed laparoscopically. Patients were predominantly male (72.0%), with a lower age at time of transplantation compared to non-BS population (54.5 vs 60.6, $p < 0.0001$). Transient acute kidney failure (20.0%) was the only short-term complication occurring in more than one patient, all after SG. Weight loss was significant and sustained, with a decrease in BMI from 41.0 ± 4.5 pre-BS to 32.6 ± 5.8 ($p < 0.0001$) 1 to 3 years post-BS and 31.1 ± 5.8 ($p < 0.0001$) 3 to 5 years post-BS. Post-LT pre-BS three (12.0%) patients presented with recurrent and one (4.0%) de novo MASLD, with 100% resolution post-BS ($p = 0.016$). Notable reductions were observed in ALT levels (40.5 ± 28.5 U/L to 27.1 ± 25.1 U/L post-BS, $p = 0.051$) and HbA1c levels (6.9 ± 1.6 to 6.0 ± 1.4 post-BS, $p < 0.0001$). Daily mycophenolic acid intake rose from 1000.0 ± 288.7 mg/day to 1392.8 ± 1619.3 mg/day ($p < 0.0001$), while the dose of ciclosporin decreased from 258.3 ± 91.7 mg/day to 146.0 ± 107.4 mg/day ($p = 0.137$). Three patients were re-transplanted, and eight patients died, of which five (20.0%) due to a non-hepatic malignancy and one (4.0%) due to liver failure. Given the small sample size and relatively high mortality due to competing risks, a statistical analysis of patient or transplant-free survival was not feasible.
**Conclusion:** SG is the favored BS post-LT and has proven to be safe and feasible in a post-LT setting. SG post-LT is a valid treatment for de novo and recurrent MASLD post-LT. Although we report on the largest cohort to date, there is still a need for larger cohorts to examine the effect of BS on graft survival.

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**Screening for asymptomatic coronary artery disease in liver transplant recipients: is it time to replace stress echocardiography with coronary CT angiography in selected patients?**

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**Background and aims:** Asymptomatic coronary artery disease (CAD) has been reported in up to 25% of liver transplant (LT) candidates. Pre-LT cardiovascular (CV) work-up is not yet standardized, but in 2022 coronary-CT angiography (c-CT) was proposed by the American Heart Association in pre-LT selected patients (pts). We aimed to compare two CV screening protocols at our large-volume transplant Centre.
**Method:** We enrolled all adult cirrhotic pts who underwent first-LT between 01/2019–12/2022 in our Center. In the first period (2019–2021) echostress (EchoS) was performed in the presence of 3 minor (age 60–64 years, arterial hypertension, non-insulin treated diabetes, BMI >29 Kg/m$^2$, CAD family history, active smoking) or 1 major CV risk factors (insulin-treated diabetes, age >64 years, peripheral vascular disease, MASLD). From 1/2022 c-CT was performed with 1 major CV risk factor, and EchoS with 3 minor CV risk factors. Coronary angiography (CATH) was performed in pts with CAD history/symptoms, positive/doubtful non-invasive test or cardiology indication. Follow-up was closed on 31/12/2023.
**Results:** 477 pts were included: 374 (78%) in first period and 103 (22%) in second one. First *vs* second period: CV risk factors prevalence was similar: age >64 years 26% *vs* 25% ($p = 0.9$), previous CAD 2% *vs* 2% ($p = 1$), male sex 74% *vs* 80% ($p = 0.2$), previous stroke/TIA 2% *vs* 2% ($p = 1$), diabetes 26% *vs* 32% ($p = 0.2$), MASLD 10% *vs* 9% ($p = 0.8$), BMI >29 Kg/m$^2$ 12% *vs* 14% ($p = 0.6$), peripheral vascular disease 1% *vs* 4% ($p = 0.07$), except for CAD family history which was higher in the first