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Introduction: Immune-checkpoint inhibitors (ICIs) increasingly downstage hepatocellular carcinoma (HCC) to liver transplantation (LT), but their sustained immune activation may heighten the risk of graft rejection when given before or after transplant. Evidence remains limited to small and heterogeneous studies, suggesting higher rejection rates with short wash-out intervals. More data are needed to define safe timing and immunosuppression strategies around transplantation in ICI-exposed patients. Therefore, real-world multicentre data are needed.
Aim: We aim to evaluate the impact of immunotherapy on graft outcomes, the risk for rejection and post-transplant HCC recurrence.
Methods: We retrospectively collected data from patients treated with ICIs between January 2020 and October 2025 who underwent liver transplantation in all transplant centres in Belgium and in Beaujon Hospital, Paris. We collected demographic data, pre-transplant HCC characteristics (number and size of nodules, alpha-fetoprotein levels), and post-transplant outcomes.
Results: We collected data from 15 patients. The cohort consisted predominantly of men (80%), with a mean age at LT of 55.6 ± 12.3 years. Cirrhosis was mainly of viral origin (40%), and alcohol-related liver disease accounted for 20%. The mean MELD score was 12.1 ± 4.3, and most patients were classified as Child–Pugh A. The mean ALBI score was −2.2 ± 0.8. At HCC diagnosis, patients had on average 2.1 nodules, and the median size of the largest lesion was 55 mm (range 24–119). BCLC stage was B in most patients (80%), while two were classified as BCLC C and one as BCLC D. Mean alpha-fetoprotein at LT was 29.9 ng/mL. All but one patient received Atezolizumab plus Bevacizumab before LT. One patient received Durvalumab for a mixed HCC–iCCA lesion with predominant intrahepatic cholangiocarcinoma features. The median washout period between immunotherapy and LT was 5 months (range 1–23). The mean interval between HCC diagnosis and LT was 27.4 ± 19.6 months. Six patients (40%) underwent additional bridging therapies (radio- or chemoembolization, external radiotherapy, microwave ablation, etc.). On the liver explants (N = 12), 30% were classified as disease-free (pT0N0) and 30% as pT1 (a or b) N0. Two patients were pT2N0 and two were pT3N0. After a median follow-up of 10 months (range 1–32), two patients developed recurrence at 5.5- and 13-months post-LT, respectively. One patient had been classified as pT3N0 and the other as pT1bN0 with poorly differentiated HCC. The latter patient died from oncological progression despite salvage chemo and immunotherapy. Early allograft rejection within the first postoperative month occurred in two patients, both successfully treated with steroids. Among the 11 patients with available data on induction therapy, 8 received Basiliximab. Six patients are currently maintained on tacrolimus monotherapy without additional immunosuppressive agents.
Conclusions: Immunotherapy prior to liver transplantation appears feasible in carefully selected patients, with acceptable rates of rejection and early post-transplant outcomes. In our cohort, ICIs effectively contributed to tumour control and downstaging, enabling access to LT in patients with advanced HCC. However, longer follow-up and larger prospective studies are required to better assess the long-term risk of recurrence and to refine optimal timing and immunosuppression strategies in ICI-exposed candidates.

-A15-

THE NATURAL HISTORY OF PORTO-SINUSOIDAL VASCULAR DISORDER WITHOUT PORTAL HYPERTENSION: A MULTICENTRE RETROSPECTIVE VALDIG STUDY. E. Kaze (1), S. Raevens (2), G. Dahlqvist (3), M. Saracco (4), L. Moga (5), N. Pugliese (6), E. Farina (7), E. Murcia (8), L. Balcar (9), C. Boros (10), M. Lucà (11), L. Argiento (12), H. Giudicelli (13), T. Vanwolleghem (14), A. Driessen (15), S. Shalaby (16), W. Ramírez-Quesada (16), D. Tazibt (17), O. Goria (18), L. Elkrief (19), J. Delwaide (20), A. Marot (21), Q. Schoevaerdts (21), C. Moreno (1), J. Cervoni (17), V. Hernandez-Gea (16), J. Garcia-Pagan (16), S. Francque (14), D. Thabut (13), C. Cafasso (22), M. Ziol (23), P. Nahon (10), G. Semmler (9), B. Scheiner (9), C. Bureau (8), M. Vigano (7), A. Loglio (7), A. Aghemo (6), A. Plessier (24), P. Rautou (24), P. Baldin (25), L. Verset (26), A. Hoorens (27), P. Deltenre (28) / [1] CUB Hôpital Erasme, Belgium, Department of Gastroenterology, Hepatology and Digestive Oncology, [2] University Hospital Ghent (UZ Gent), Gent, Belgium, Liver Research Centre Ghent, [3] Cliniques universitaires Saint-Luc, Brussels, Belgium, Brussels,

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Introduction: Data on the natural history of patients with histological lesions of a porto-sinusoidal vascular disorder (PSVD) who do not show signs of portal hypertension (PH) are scare. **Aim:** Describe the natural history of these patients and identify risk factors for disease progression. **Methods:** A retrospective study was conducted to collect health-related data on patients with a histopathological diagnosis of PSVD and no signs of PH, across 17 Vascular Liver Disease Group (VALDIG) centres. Patients with a platelets count <150,000/mm3, a splenomegaly >130 mm, ascites, esophageal or gastric varices, or any other obvious portosystemic collateralization were excluded. The liver tissue sample should be at least 15 mm long. A central review of the liver tissue sample had not yet been performed at this stage. According to previous definitions, associated conditions were defined as the use of any medication or the presence of any immunological, haematological, congenital, or hereditary disease that could induce PSVD. Associated conditions were considered severe if they may be potentially associated with reduced life expectancy. Main endpoints were the development of PH (either ascites, obvious portosystemic collateralization, or oesophageal or gastric varices) and death. **Results:** 227 patients were included (92 men [41%], median age 46 years [95% CI: 43-50]). Indication for liver tissue sampling was abnormal liver tests in 186 patients (82%). Main laboratory values at diagnosis were as follows: AST 41 U/L (95% CI: 35-43); ALT 56 U/L (95% CI: 48-64); alkaline phosphatase 113 U/L (95% CI: 102-121); GGT 132 U/L (95% CI: 115-152); bilirubin 1 mg/dL (95% CI: 1-2); albumin 42 g/L (95% CI: 41-43); INR 1 (95% CI:1-1); platelets count 246,000/mm3 (95% CI: 236,000-260,000). The length of the liver tissue sample was 31 mm (95% CI: 30–34 mm). Histological findings were nodular regenerative hyperplasia, obliterative portal veinopathy, incomplete septal cirrhosis, a combination of these histological lesions, as well as sinusoidal dilatation with or without other signs indicative of PSVD, in 126 (56%), 41 (18%), 2 (1%), 14 (6%) and 44 (19%) patients, respectively. Associated conditions were observed in 100 patients (46%), of which 55 (24%) were considered as severe. During a median follow-up of 37 months (95% CI: 27-46), 3 patients developed portal vein thrombosis. One of these patients had tumoural portal vein thrombosis related to metastatic colorectal neoplasia. Three patients (1.3%) developed PH-related manifestations (ascites in 2 patients and esophageal or gastric varices in one patient). Nineteen patients (8%) died, 17 from non-hepatic causes and two from complications related to preexisting cholangiocarcinoma. No patient died from a PH-related complication. One underwent liver transplantation for colorectal carcinoma-related liver metastasis. Compared to those who did not, patients who developed PH-related manifestations were older on average (61 vs. 45 years, p=0.11), had higher alkaline phosphatase level (241 vs. 111 IU/L, p=0.016), and similar platelets count (245,000 vs. 305,000/mm3, p=0.3). All patients who developed PH-related manifestations had associated conditions. The cumulative incidence of PH-related manifestations at 10 years was 6% (95% CI: 2–20%): 12% (95% CI: 4–35) in patients with an associated condition versus 0% in those without (p = 0.09). Compared to patients who did not die, those who died were older (58 vs. 45 years, p<0.001), had higher AST

levels (116 vs. 38 IU/L, p<0.001), higher ALT levels (125 vs. 54 IU/L, p=0.004), lower haemoglobin levels (108 vs. 137 g/dL, p=<0.001), lower platelets count (208,000 vs. 248,000/mm3, p=0.05), more frequent associated conditions (15 [79%] vs. 85[41%], p=0.003), and more frequent severe associated conditions (14 [74%] vs. 41 [20%], p<0.001). Independent predictors of death were age (relative risk [RR]: 1.07, 95% CI: 1.03, 1.11, p<0.001) and presence of a severe associated condition (RR: 4.76, 95% CI: 1.55–14.65, p=0.006). The 10-year survival rate was 84% (95% CI: 77–92%): 95% (95% CI: 89-100) in patients without an associated condition, 100% in patients with a non-severe associated condition, and 58% (95% CI: 41-76) in patients with a severe associated condition (p<0.001).
Conclusions: Most patients with PSVD who did not present with PH will not develop it. Sixteen per cent of patients die within 10 years, mostly from non-hepatic causes, and the risk of death is independently associated with the severity of the associated condition.

-A16-

CORTICOSTEROIDS ARE INEFFECTIVE IN INDIVIDUALS WITH SEVERE ALCOHOL-ASSOCIATED HEPATITIS AND EARLY SPONTANEOUS IMPROVEMENT: A MULTICENTRE BELGIAN RANDOMIZED PLACEBO-CONTROLLED TRIAL. C. Moreno (1), P. Deltenre (2), A. Marot (3), H. Njimi (4), L. Lasser (5), D. Degré (6), A. Hittelet (7), J. Delwaide (8), A. Geerts (9), S. François (10), B. Bastens (11), T. Gustot (6), E. Trépo (6) / [1] Erasme Hospital, Brussels, Belgium, Department of Gastroenterology and Hepatopancreato, [2] Clinique Saint-Luc Bouge ; CHU UCL Namur ; CUB Hôpital Erasme, Belgium, Department of Gastroenterology and Hepatology, [3] CHU UCL Namur, Yvoir, Belgium, Department of Gastroenterology and Hepatology, [4] Erasme University Hospital - Université Libre de Bruxelles (ULB), Bruxelles, Belgium, Biomedical statistics, [5] CHU Brugmann, Brussels, Belgium, Department of Hepatogastroenterology, [6] Erasme University Hospital - Université Libre de Bruxelles (ULB), Bruxelles, Belgium, Department of Gastroenterology, Hepatopancreatology and Digestive Oncology, [7] CHU Ambroise Paré MONS, Mons, Belgium, Department of Gastroenterology, [8] CHU Liege, Liège, Belgium, Department of Hepatogastroenterology, [9] Ghent University Hospital, Gent, Belgium, Belgium, Department of Hepatogastroenterology, [10] University Hospital Brussels, Vrije Universiteit Brussel, Belgium, Department of Hepatogastroenterology, [11] Clinique MontLégia- CHC Groupe Santé, Liège, Belgium, Department of Gastroenterology.

Introduction: Severe alcohol-associated hepatitis (AH) is a life-threatening disease for which corticosteroid therapy is recommended in the absence of contraindication. A significant proportion of patients with severe AH have a spontaneous serum bilirubin decrease early after admission.
Aim: Our aim was to determine whether corticosteroid therapy is more effective than placebo in individuals with severe AH and early spontaneous improvement.
Methods: In this multicentre, randomized, controlled trial conducted between February 2018 and May 2024 in 10 Belgian hospitals, patients aged 18 or older, who were heavy drinkers, with recent onset of jaundice, with a biopsy-proven severe AH (mDF[3]32 at admission), and with a spontaneous early improvement (i.e. serum bilirubin level decrease > 10% at day 5-10 after admission) were randomized to either corticosteroids (CS) (methylprednisolone 32 mg/d) or placebo (P) for 28 days. Primary endpoint was to compare 3-month mortality rate between both groups of treatment. Secondary endpoints were to compare 1-month mortality rate and infection rate during study period between both groups.
Results: A total of 69 patients were randomized, 38 in the corticosteroid group and 31 in the placebo group. Baseline characteristics were not significantly different between the two groups (CS vs P) for age (52±8 vs. 51±10), male gender (76% vs. 63%), total bilirubin (7.4[5.1-10.8] vs. 9.3[6.0-17.6] mg/dL), INR (1.64 [1.48-1.80] vs 1.70 [1.48-1.98]), mDF at admission (44[37-57] vs. 45[40-58]) and MELD score (21[19-23] vs 21[19-24]). Decrease in bilirubin level between admission and screening was not different between both groups (31±15% vs 27±11%). Lille score at day 7 of treatment was 0.18 [0.07-0.30] and 0.18 [0.07-0.40] in CS and P group, respectively (p>0.9). At 3 months, the probability of survival was not different between both groups (83[72-96] vs 82[69-98] % in CS and P groups respectively, p=0.88). There was no difference in the probability of 1-month survival between CS and P groups (95[88-100] vs 94[85-100] %, p=0.85). Probability of infection during the study period was 48 % in the CS group and 36 % in the P group (p=0.41). Age and Lille score were significantly associated with 3-month survival. The study was prematurely interrupted due to a low recruitment rate.
Conclusions: The present study failed to identify any benefit from corticosteroid therapy in patients with severe AH and early decrease in bilirubin level after admission. Even if the number of included patients initially planned was not reached, it is unlikely that corticosteroids provide a survival benefit when bilirubin