and accelerated fibrosis in HCV pre-transplantation. Direct FXa inhibition and warfarin anticoagulation both ameliorate hepatic fibrosis in animal models. There is now a need to evaluate the effect of anticoagulation on hepatic fibrosis in human studies.

Aims: To evaluate the safety and impact of warfarin anticoagulation on liver fibrosis progression in patients transplanted for HCV infection.

Material and Methods: WAFT-C is a prospective multi-centred, randomised open-label controlled trial designed to investigate the impact of anticoagulation on fibrosis progression over one and two years post liver transplantation. Patients are randomised by centre and gender to standard post transplant care (control group) or standard of care with warfarin anticoagulation maintaining an INR between 2–3 (warfarin group). Interim intention to treat and per protocol analyses were undertaken for fibrosis scores at year one post transplantation. The primary endpoint was the proportion of patients with an increase of ≥2 in their Ishak fibrosis score by per protocol analysis.

Results: 76 patients have been randomised (control group: n = 39; mean age 52.3 yrs; M:F=33:6. warfarin group: n = 37; mean age 53.2 yrs; M:F=30:7). Intentional to treat analysis of year one fibrosis scores (n = 65) indicates a non-significant reduction in the proportion of patients with an increase in fibrosis score between the control and warfarin groups (26% vs 13%, p > 0.05). Per protocol analysis (n = 53) after exclusion of biliary disorders (control group n = 2, warfarin group n = 3) and non compliant patients (failed to start anticoagulation, n = 5; <8 weeks of anticoagulation, n = 2) demonstrated a significant reduction in the proportion of patients with an increase in fibrosis score between the control group and warfarin group at year one (23.3% vs 0%, p = 0.01). No patients were withdrawn due to severe adverse events directly secondary to anticoagulation.

Conclusions: Results of the one year endpoint suggest that warfarin anticoagulation may benefit in reducing HCV related fibrosis one year post transplantation. Two year endpoint data is required to validate these findings.

LP12
SILYMARIN FOR THE TREATMENT OF NON-ALCOHOLIC STEATOHEPATITIS: INTERIM ANALYSIS OF A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL
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Introduction: Silymarin, derived from the milk thistle plant, Silybum marianum, has been used as a herbal remedy for diseases of the liver. Its anti-oxidant, anti-inflammatory and anti-fibrotic properties have been demonstrated in various in vitro and animal models, and may be useful for the treatment of non-alcoholic steatohepatitis (NASH).

Material and Methods: This is a randomized, double-blind, placebo-controlled study of silymarin 700 mg t.i.d. for the treatment of NASH. All included patients had biopsy-proven NASH, were given lifestyle advice, and received either silymarin or placebo for 48 weeks. A repeat liver biopsy was performed at the end of the study. Histology was reported using the NASH Clinical Research Network scoring system. A total of 64 patients completed the study at the time of this interim analysis. Mean age was 50.2±11.4 years and consisted of 43.8% males. The baseline characteristics were comparable between the silymarin (n = 30) and placebo (n = 34) groups. The primary endpoint of the study (defined as at least 30% improvement in the non-alcoholic fatty liver disease activity score, NAS) was met in a higher percentage of patients in the silymarin group compared to the placebo group but this was not statistically significant (33.3% vs. 20.6%, p = 0.517). Patients in both the silymarin and placebo groups experienced significant improvement in NAS (Δ = −0.733, p = 0.003 in the silymarin group; Δ = −0.706, p = 0.006 in the placebo group). The percentage of patients with improvement in NAS was not significantly different between the silymarin and placebo groups (60.0% vs. 58.5%, p = 0.924). However, significantly more patients in the silymarin group experienced NAS resolution (defined as NAS <3) compared to the placebo group (13.3% vs. 0%, p = 0.043). There was also a significant decrease in the fibrosis stage in the silymarin group (Δ = −0.367, p = 0.019). This was not observed in the placebo group (Δ = +0.147, p = 0.282). A significantly higher percentage of patients in the silymarin group had improvement in fibrosis stage compared to the placebo group (36.7% vs. 14.7%, p = 0.043). In addition, four patients in the placebo group developed cirrhosis while none of the patients in the silymarin group did.

Conclusions: A significantly higher percentage of patients experienced NAS resolution and improvement in fibrosis stage after 48 weeks of treatment with silymarin compared to placebo.

LP13
EFFECT OF LONG TERM VIRAL SUPPRESSION WITH SOFOSBUVIR + RIBAVIRIN ON HEPATIC VENOUS PRESSURE GRADIENT IN HCV-INFECTED PATIENTS WITH CIRRHOSIS AND PORTAL HYPERTENSION
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Introduction: Portal hypertension is a major predictor of clinical outcomes and anti-viral response in HCV cirrhosis. The effect of viral suppression and SVR on HVPG has not been characterized in patients treated with DAA’s. Fifty CPT A (n=18) and B (n=32) cirrhotic patients with portal hypertension (HVPG >6mmHg), were randomized to receive 48 weeks of open-label sofosbuvir 400 mg and ribavirin at Day 1 or after a 24 week observation period. The primary endpoint was SVR12. Secondary endpoints included changes in HVPG, laboratory parameter values, MELD and CPT scores.

Results: Patients were predominantly male (76%), Caucasian (90%), prior treatment failures (80%), genotype 1 and 3 (88%) with mean baseline HCV RNA 6.1 log10 IU/mL. In the observation arm, 4 patients discontinued and never received treatment. All patients who completed treatment had viral suppression to undetectable by week 8 on treatment and SVR12 was achieved in 72% (33/46) of patients (2 on-treatment failures and 11 relapses). At study entry mean baseline HVPG was 16.4 mmHg in the observation group and 17.5 mmHg in the treatment group. Over the 24 week observation period the median change in HVPG was 0 mmHg (−7.0 to +4.5 mmHg). Of the 37 patients who had paired baseline and end of treatment (EOT) HVPG measurements there was a median change of −0.5 mmHg. Of the 33/37 (89%) patients with HVPG ≥12 mmHg at baseline, a ≥20% decrease from baseline was observed in 8/33 (24%) patients at the EOT and 4 patients reduced their pressure to less than 12 mmHg (see figure). Improvements in MELD score from baseline to follow-up week 4 were seen in 37% (15/41) of patients with an average decline of −1.6. Improvement in CPT score was seen in 69% (18/26) of CTP B patients. In an
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