

Methods: DCDs donors offered to our center were retrieved after a period of NRP. Graft eligibility to transplantation was assessed on NRP parameters.

Grafts were then transported to our center and randomized to NMP or D-HOPE and transplanted after a variable period.

Results: Between January 2021 to November 2023, 29 liver grafts were procured and transplanted, being 13 assigned to DHOPE and 16 to NMP group. Median donor age was 62 and 57 years ($p=0.12$) in D-HOPE and NMP group, respectively, being 11 (38%) grafts older than 80 years. 90-day graft survival was 84% versus 100% ($p=0.12$) in D-HOPE and NMP group respectively.

No differences in terms of post-reperfusion syndrome rate (31% versus 31%, $p=0.97$), early allograft dysfunction rate (31% versus 19%, $p=0.56$), ICU stay (6,1 versus 4,7 days, $p=0.57$), hospital stay (15,9 versus 15,5 days, $p=0.92$) were noted in the D-HOPE and NMP group, respectively.

There were 5 cases of biliary complications in NMP group (2 ischemic cholangiopathy, 1 anastomotic stricture and 2 leakages) vs 2 (2 anastomotic strictures) in D-HOPE group ($p=0.3$).

Conclusions: The sequential use of NRP and end-ischemic machine perfusion is a safe method to perform DCD liver transplants with extended warm ischemia time without donor age limits. No major differences between D-HOPE and NMP have been showed. Further data are needed to draw definitive conclusions.

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Acute-on-chronic liver failure in severe acute alcoholic hepatitis: impact on management, prognostication, and urgency of liver transplantation

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Introduction: A better identification of factors predicting the course, outcome, and need for urgent liver transplantation in patients with severe acute alcoholic hepatitis (SAAH) is needed. Acute-on-chronic liver failure (ACLF) can occur in SAAH, and its impact on management, prognostication, and need for urgent liver transplantation in SAAH should be clarified.

Aim: To describe the impact of ACLF on management, prognostication, and need for urgent liver transplantation in SAAH.

Materials and Methods: Patients with SAAH referred to our center between April 2016 and May 2023, with those non-responders to medical treatment (MT) being evaluated for LT.

Results: One hundred patients were included, with a median Maddrey Discriminant Function of 72 and a median MELD-Na score of 28. At presentation, 52 patients had ACLF grade 0-1, and 48 ACLF grade 2-3 (31 grade 2, 17 grade 3) (see *Figure 1*). In the latter group, circulatory failure was present in 3 (6.25%), and respiratory

failure in 4 (8.3%). SAAH was the only precipitant factor in 50 (96%) and 36 (75%) patients with ACLF grade 0-1 and ACLF grade 2-3, respectively, with infection being an associated factor in 1 (2%) and 8 (17%), and GI bleeding in 1 (2%) and 5 (10%), respectively.

Non-response to MT was significantly higher in patients with ACLF grade 2-3 (39/48, 81%) than in those with ACLF grade 0-1 (14/52, 27%). ACLF grade 2-3 was associated with a corresponding higher need of early LT (ACLF grade 2-3: 14/48, 29% vs ACLF grade 0-1: 3/52, 5.7%; $p=0.004$).

ACLF status at presentation (ACLF grade 2-3 vs ACLF grade 0-1) resulted a better predictor of outcome (death or LT) than MELD-Na (\geq or $<$ 30) (4.42 [2.67; 7.33] vs 2.50 [1.51; 4.12]).

Conclusions: ACLF is a frequent presentation of SAAH. Severe ACLF predicts non-response to MT, indicating the urgency of liver transplantation.

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The equitable benefit approach (EBA): a single ethical framework to guide the assessment of medical and psychosocial factors in liver transplant candidacy

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Liver transplantation (LT) raises ethical issues because organ scarcity implies the need for equitable access and maximum benefit from transplantation through non-discriminatory eligibility criteria and allocation systems. Patient selection and LT prioritization criteria are mainly based on medical factors. However, psychosocial, and behavioral variables are having an increasing impact on the process of patient selection and on survival after LT. Ethical concerns regarding the inclusion of non-medical factors in the selection of LT candidates are related to their potential impact on health equity issues, discrimination, and stigma. Thus, there is a need to provide ethical guidance in the assessment of LT candidacy, considering both medical and psychosocial aspects in a single framework. The aim of this paper is to present the ethical foundations of a framework proposed by the multidisciplinary group of clinical experts in LT (CELT group) of the Italian Association for the Study of the Liver (AISF). First, the updated selection and prioritization criteria for LT based on pure medical factors are presented. Then, a specific ethical framework, called Equitable Benefit Approach (EBA), is presented to provide ethical guidance in LT candidacy and prioritization. EBA clarifies the overarching goals of LT and illustrates and ranks the principles that should guide allocation decisions in LT, distinguishing between substantive and procedural principles. It also integrates medical and psychosocial criteria into a single operational algorithm to guide the selection process, prioritization, and post LT follow-up. Finally, potential strategies for implementing this proposed approach in clinical practice are presented.

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