**Methods**

**Study design**
- Study type: Interventional
- Allocation: Randomized Controlled Trial
- Masking: Double-blind

**Experimental group:** Viusid (a nutritional supplement)
- Control group: Placebo

**Assignment:** Placebo
- Endpoint: Clinical efficacy and safety of Viusid, a nutritional supplement, in chronic hepatitis C and cirrhosis

**Exclusion criteria:**
- Patients with chronic hepatitis C with cirrhosis who had clinically suspected or histologically confirmed cirrhosis were randomly assigned in a 1:1 ratio to receive 3 sachets of Viusid or placebo daily for a maximum of 96 weeks.

**Inclusion criteria:**
- The antagonist therapy has not been tested in patients with hepatitis C and cirrhosis

**Statistical analysis**
- Intention to treat analysis included all patients who were randomly assigned to receive either Viusid or placebo.
- Treatment was compared with the use of a Cox proportional-hazards model.

**Data from patients without end points were censored at the last date of available follow-up after treatment.

**A two-sample t-test was used to compare differences between the groups for continuous variables.

**Table 1. Baseline characteristics of the patients**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Viusid (n=45)</th>
<th>Placebo (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>60 ± 10</td>
<td>57 ± 9.7</td>
</tr>
<tr>
<td>Sex (female)</td>
<td>14 (31%)</td>
<td>13 (26%)</td>
</tr>
<tr>
<td>Male</td>
<td>26 (58%)</td>
<td>37 (74%)</td>
</tr>
<tr>
<td>Race</td>
<td>22 (49%)</td>
<td>26 (52%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>23 (51%)</td>
<td>29 (58%)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>60 ± 10</td>
<td>57 ± 9.7</td>
</tr>
<tr>
<td>Body mass index</td>
<td>25.5 ± 3.2</td>
<td>25.1 ± 3.2</td>
</tr>
<tr>
<td>waist circumference (cm)</td>
<td>91 ± 13</td>
<td>91 ± 13</td>
</tr>
<tr>
<td>Blood pressure (mmHg)</td>
<td>132 ± 13</td>
<td>134 ± 15</td>
</tr>
<tr>
<td>Fasting insulin (μU/mL)</td>
<td>14 ± 3.4</td>
<td>15 ± 3.4</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>8.5 ± 1.1</td>
<td>8.6 ± 1.1</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>8.5 ± 1.1</td>
<td>8.6 ± 1.1</td>
</tr>
<tr>
<td>Vascular disease</td>
<td>19 (42%)</td>
<td>24 (48%)</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>13 (29%)</td>
<td>20 (40%)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12 (27%)</td>
<td>13 (26%)</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Obstructive lung disease</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

**Conclusion**

Viusid tolerability was excellent and no severe adverse events were associated with the use of Viusid.
DEFINING THE IMPACT OF ORGAN DYSFUNCTION IN CIRRHOSIS: SURVIVAL AT A COST?


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Introduction: The incidence of cirrhosis is increasing exponentially and it is projected that there will be a 5 fold increase in demand for liver transplantation in the next 6–10 years. Historically, the perception of cirrhosis with organ dysfunction as having a poor prognosis has fuelled a self-fulfilling prophecy with inquisitive access to intensive care (ICU). However, recent data to support this view is lacking. We report the 7 year experience of the outcome, physiological disturbance and resource utilisation of 658 emergency admissions with cirrhosis and organ dysfunction to a specialist liver ICU.

Aims and Methods: We prospectively collected and analysed physiological and biochemical variables on day 1/3 of admission. Outcome variables, organ scores [Child Pugh, MELD, SOFA and APACHE II] and number of days requiring vasopressors, ventilation and renal replacement therapy (RRT) were recorded. The Therapeutic Intervention Scoring System (TISS) score, validated as a tool for estimating cost in ICU, was calculated.

Results: Alcohol was the most common aetiology (47%) and variceal bleeding the most common reason for admission (35%). 51% required inotropes, 72% invasive ventilatory support and 49% RRT. Despite this, ICU admission for many of these patients was not futile, with 55% surviving their ICU stay and 41% surviving to discharge. Variceal bleeders had a 30 day survival of 53% versus 33% with a non-variceal indication for admission (p < 0.0001). 19% of survivors subsequently underwent transplantation. Survival was at a significant cost [median cost/patient: £12,403 (4,636–27,283) for a median 7 day admission (3–15)]. Admissions with multi-organ failure (MOF) score significantly more (MOF p < 0.001; RRT p < 0.0001) and had more prolonged lengths of stay (p < 0.001). RRT was well tolerated and facilitated recovery in 23/59 (39%) patients who were subsequently transplanted.

Conclusion: More than 50% of patients admitted as emergencies will survive their ICU stay with the majority surviving to hospital discharge. These data challenge the widely held prejudice that patients with cirrhosis requiring emergency admission to ICU inevitably die. This endorses the establishment of managed clinical care networks and demands the engagement of all levels of critical care and ward-based care models in the treatment of organ dysfunction in cirrhosis.

HYDROXYZINE IMPROVED INSOMNIA IN CIRRHOTIC INPATIENTS WITH GRADE I ENCEPHALOPATY


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Introduction: Sleeplessness frequently occurs in cirrhotic patients with mild hepatic encephalopathy. The central histaminergic system is implicated in the control of arousal and circadian rhythmicity. In these patients histamine neurotransmission is altered and it modifies circadian rhythmicity. A selective up-regulation of brain H1 could contribute to the neuropsychiatric symptoms characteristic of human HE, and may be amenable to treatment with selective histamine H1 receptor antagonists.

Aims and Methods: We have studied the effects of hydroxyzine (histamine H1 blocker) in sleep alterations in cirrhotic inpatients with mild encephalopathy. We were also interested to evaluate this drug security and its adverse effects. This is a prospective, randomized study.

24 consecutive inpatients with hepatic cirrhosis with portal hypertension with hepatic encephalopathy were included during 12 months. The mean age was 67 years (27–78) and mean Child–Pugh score was 9 (7–15).

Patients with TIPS or surgical shunts were excluded. Benzodiazepines consumers and patients with alcoholic deprivation were also ruled out.

The 24 patients were randomized to have hydroxyzine 25 mg at 23:00 p.m. (n = 12) or placebo (n = 12) during a week.

Results: Subjective sleep improvement evaluated by the “Epworth Sleepiness Scale” was observed in 66.6% of hydroxyzine-treated patients but in none receiving placebo (p < 0.05).

Hepatic encephalopathy deterioration happened in two of hydroxyzine-treated patients and in one of placebo-treated group (non statistical significance).

All these patients improved after conventional treatment and cessation of hydroxyzine (in those patients who were having it).

Conclusions: Hydroxyzine 25 mg at 23:00 p.m. improved sleeplessness in patients with cirrhosis and mild encephalopathy. Risk of encephalopathy deterioration was not higher in the hydroxyzine group.

VIUISID, A NUTRITIONAL SUPPLEMENT, IN PATIENTS WITH CHRONIC HEPATITIS C AND CIRRHOSIS. A RANDOMIZED AND CONTROLLED STUDY

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Introduction: Recent studies have validated the feasibilities of IFN-based therapies for decompensated cirrhotic patients but have provided no data on benefit of therapy in disease progression and survival rates.

Aims: The efficacy and safety of antioxidant therapy in preventing disease progression in patients with chronic hepatitis C with compensated and decompensated cirrhosis is unknown.

Methods: One hundred patients with chronic hepatitis C who had clinically suspected or histologically confirmed cirrhosis were randomly assigned in a 1:1 ratio to receive 3 sachets of Viusid or placebo daily for a maximum of 96 weeks. The primary end point was the survival rate and the secondary end points were time to disease progression, defined as clinical hepatic decompensation (ascites, encephalopathy, bleeding gastroesophageal varices and spontaneous bacterial peritonitis) or MELD score impairments of at least 4 points as compared with the pretreatment score, and hepatocellular carcinoma. An independent data and safety monitoring board monitored the progress of the study and performed interim analyses of the data. The study was terminated after a median duration of treatment of 64 weeks (ranges, 24–96) owing to a significant difference between each group of treatment and number of end points reached.

Results: Primary end point was reached by 92 percent (46 of 50) of patients receiving Viusid and 72 percent (36 of 50) of those receiving placebo (hazard ratio, 3 [95%CI. 1.09–9.2]; P = 0.035). The secondary end point was reached by 50 percent (25 of 50) of patients receiving placebo in comparison with 25 percent (9 of 50) of those receiving Viusid (hazard ratio for time to disease progression, 3 [95%CI. 1.4–6.6]; P = 0.002).

Hepatocellular carcinoma occurred in 5 patients assigned to placebo as compared with 1 patient assigned to Viusid (hazard ratio, 3.9 [95%CI. 0.5–33]; P = 0.17). Viusid tolerability was excellent and none severe adverse event was reported.

Conclusions: Continuous treatment with Viusid delays clinical progression in patients with chronic hepatitis C and cirrhosis by significantly reducing the time to disease progression and increasing the survival rates.