than 10 is significant PH above which the complications like variceal bleed and ascites develop. Currently proposed classification of cirrhosis is based on the degree of PH and associated clinical features. Development of ascites, variceal bleed and hepatic encephalopathy is considered to be decompensated cirrhosis. PH results from increase in the intrahepatic resistance which has dynamic and fixed components and it is coupled with increase in the portal blood flow. Therapeutic interventions which can reduce the HVPG like non selective beta blockers and Transjugular intrahepatic porta systemic shunt (TIPS) can be helpful in combating complications of cirrhosis. And they have been shown to improve survival. Bacterial infection is common in cirrhosis with one month mortality of 30%. Oral prophylactic antibiotics or bowel decontamination have shown to improve long term outcome in patients with decompensated cirrhosis. Malnutrition is common in all patients with cirrhosis. Now it is clear there is no need of restricting the proteins in these patients. In fact nutritional therapy can improve survival, reduce the rate of infections, stay in ICU and hospital, and reduce post operative complications. Screening for hepatocellular carcinoma (HCC) can pick up very early disease and survival can be improved in these patients by offering curative treatment. Therapeutic modalities can reverse the cirrhosis. These modalities according to the etiology are (1) abstinence for alcoholic cirrhosis, (2) antiviral therapy for hepatitis B, (3) immunosuppression for autoimmune hepatitis, (4) relieving biliary obstruction in patients with secondary biliary cirrhosis, (5) antiviral therapy for hepatitis C and (6) relieving obstruction in patients with Budd Chiari syndrome. Future therapies like antifibortic, antiangiogenic and anti coagulants may have potentials reducing fibrosis, reversing cirrhosis. Stem cell therapy may be helpful in patients with liver cirrhosis.

**CS16.3** New concept in nomenclature, classification and diagnosis of liver failure

Y.M. Wang*. Chongqing, China

Abstract not available

**CS16.4** Treatment strategy developments of hepatitis B with liver failure

Z.L. Gao*. Guangzhou, China

Abstract not available

**Free Paper Presentation 1: Hepatitis C**

Friday, July 15, 2011, 15:30–17:00

Meeting Room 310

**PL-001** USP18 stimulates HCV production in vitro: a novel mechanism for HCV resistance to interferon therapy

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**Background:** The molecular mechanisms of interferon resistance in almost 50% of the HCV infected patients remain unclear. We have previously identified that upregulation of interferon stimulated genes (ISGs), such as Interferon Stimulated Gene15 (ISG15) and Ubiquitin Specific Protease 18 (USP18) in hepatocytes, predicts treatment failure. Moreover, silencing USP18 potentiates IFN anti-HCV activity and increased expression of ISG15 promotes HCV production. In this study we investigate the role of USP18 in HCV production.

**Methods:** We studied the effect of over-expression of wild type (catalytically active) USP18 or an enzymatically inactive mutant form of USP18 on HCV RNA replication and viral production in JFH1 culture system. Levels of various ISGs and of the critical miRNA 122 were assessed by real-time PCR, and surface expression of the key HCV entry receptor, CD81, were quantified by FACS.

**Results:** Over-expression of wild type and mutant USP18 increases HCV production at baseline (without IFN) and blunts the anti-HCV activity of IFNα in the JFH1 infectious system. While neither ISG expression nor miRNA 122 levels were unaffected by overexpression of USP18, whether in the presence or absence of IFNα, surface expression of CD81 was increased following USP18 over-expression in HuH7.5 cells.

**Conclusions:** These data indicate that USP18 overexpression leads to increased HCV production independent of its catalytic activity, and in concert with increased surface expression of CD81. Thus, USP18, one of the ISGs increased in chronic HCV infection, stimulates HCV production and likely contributes to treatment failure by promoting HCV cell entry and blunting IFN anti-HCV activity.

**OL-001** Clinico-epidemiological profile of patients with hepatitis C virus infection seen in private practice clinics in Metro Manila

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**Background:** Hepatitis C virus (HCV) infection is a major public health problem worldwide. In the Philippines, there are few published data on the clinico-epidemiological profile of patients with HCV infection.

**Methodology:** Out-patient charts of patients seen from October 2005 to November 2010 in private practice clinics of 3 gastroenterologists were reviewed. All patients with a positive anti-HCV and/or HCV-RNA were included. Clinical and epidemiologic information were collected and analyzed.

**Results:** Of 49 patients included, 27 (55%) were males. Mean age at diagnosis was 48.5 years. 26 patients had HCV genotype data – genotype 1 in 16 (61%) patients, genotype 2 in 8 (31%), genotype 4 in 2 (8%). The most common risk factor was blood transfusion before 1990 identified in 18 (37%) patients. Other risk factors identified: injection drug use (IDU) 7 (14%), hemodialysis (HD) 7 (14%), unknown 11 (23%), others 5 (12%). At presentation, 17 (35%) patients had advanced HCV-related liver disease – 13 cirrhosis only and 4 hepatocellular carcinoma (HCC). Among 37 evaluable treatment-naïve patients, 16 (43%) were ineligible for treatment with advanced HCV-related liver disease (69%) as the most common reason.

**Conclusion:** In this study, blood transfusion before 1990, IDU, and HD were the most common risk factors for HCV infection. Many patients had advanced liver disease precluding eligibility for therapy. Screening for HCV among those with a history of blood transfusion before 1990, IDU, and HD may help identify HCV-infected patients early allowing institution of antiviral therapy to prevent progressive liver disease.

**OL-002** Could fulvastatin affect the sustained virological response in chronic hepatitis C virus treatment?

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**Background:** Hepatitis C viral (HCV) infection is the leading cause of death due to liver disease. Additional agents are