its recognition and management is important in an effort to establish strategies to improve graft/patient survival after LT.

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COMPLICATIONS AND MORTALITY AFTER ADULT TO ADULT LDLT
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Background and Aims: Living donor liver transplantation (LDLT) is widely performed for patients to resolve the critical shortage of organs from cadavers. Despite rapid implementation of the procedure, both complications and mortality of LDLT are annoying problems. The aim of this study was to analyze complications and mortality of patients after adult to adult LDLT in a single center.

Methods: Between April 2003 and February 2013, we performed 167 adult to adult LDLT in National Liver Institute, Egypt. We retrospectively analyzed complications and mortality in recipients.

Results: The overall incidence of complications was 86.2% (n=144) and classified as biliary 43.7% (n=73), vascular 21.6% (n=36), SFSS 12.6% (n=21), GIT 19.8% (n=33), wound 12.6% (n=21), chest 19.8% (n=33), neurological 26.3% (n=44), renal 21% (n=35), intra abdominal collection 21.6% (n=36), recurrent HCV 16.8% (n=28), recurrent HCC 2.4% (n=4), acute rejection 19.2% (n=32), 65 (45.1%) of 144 complicated patients died, while 10 (43.5%) of 23 non complicated died. The incidence of whole, in hospital and late mortalities were 44.9%, 28.7% and 16.2% respectively.

Conclusions: Mortality was higher among complicated cases where Vascular complications and SFSS had significant effect on it so prevention and treatment of them is required for improving outcome.

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FIRST CASE REPORT OF A PATIENT WITH FIBROSING CHOLESTATIC HEPATITIS C AFTER LIVER TRANSPLANTATION TREATED WITH SOFOSBUVIR AND SIMEPREVIR
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Background and Aims: Fibrosing cholestatic hepatitis (FCH) is a life threatening complication of HCV recurrence after OLT.

Methods: Here we report the first successful treatment of a patient with sofosbuvir/simeprevir/ribavirin (SOF/SMV/RBV) over so far 9 weeks.

Results: The 59 y old female patient underwent retransplantation on 9.6.2013 for decompensated HCV cirrhosis of the graft. Immunosuppression comprised of basiliximab induction, cyclosporine and prednisolone. Ten weeks afterwards she developed jaundice, a declining liver function (bilirubine 16.8 mg/dl, ASAT 89 U/l, ALAT 53 U/l, albumine 24 g/l) and a high HCV load (4×10^8 U/ml, genotype 1c, previous non-responder). Liver biopsy showed features of FCH. On 26.8.2013 treatment with PEG-IFN alpha 2b, ribavirin and 10 days later with telaprevir was initiated. Severe side effects occurred (anemia requiring erythropoietin, leukopenia requiring GCSF, fever, severe malaise, nausea). On 18.9.2013 access to compassionate use of sofosbuvir and simeprevir was granted. PEG-IFN and telaprevir were stopped and sofosbuvir/simeprevir started. After 8 weeks of sofosbuvir/simeprevir/ribavirin HCV was undetectable and liver parameters almost normalized (bilirubine 1.5 mg/dl, ASAT 28 U/l, ALAT 43 U/l). No serious side effects occurred, Erythropoietin and GCSF could be stopped. The patient’s general condition improved. Cyclosporine levels were stable under sofosbuvir/simeprevir/ribavirin. Further follow-up will be given at the meeting.

Conclusions: The combination of sofosbuvir, simeprevir and ribavirin seems to be a hopeful option for difficult to treat patients with severe chronic hepatitis C after liver transplantation.

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DONOR’S AND RECIPIENT’S DIABETES ARE INDEPENDENTLY ASSOCIATED WITH MORTALITY IN LIVER TRANSPLANT RECIPIENTS
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Background and Aims: Type 2 diabetes (DM) has reached epidemic proportions. DM has been shown to negatively impact the outcome of patients with chronic liver disease.

Aim: To evaluate the impact of DM on the liver transplant (LT) outcomes.

Methods: The study cohort included adults (≥18 years) who received LT in the United States between 1987–2013 (The Scientific Registry of Transplant Recipients). Extensive clinical and outcomes data were available.

Results: 95,637 successful LTs were included in this analysis. Of these, 11.1% had history of DM prior to LT. The indication for LT included hepatitis C (34.2%), alcohol-related liver disease (20.5%), primary liver malignancy (13.6%) and hepatitis B (5.0%) infection. 96.84% of LTs were from deceased donors, and 7.9% of donors had history of DM. During median 72 months of follow-up (IQR=29-130 months), 35.30% recipients died and 9.78% had graft failure. In multivariable survival analysis [at least 5 years of cohort follow-up (N=33,209)], after adjustment for age, ethnicity, insurance type, history of chronic diseases, HCV infection and history of non-compliance, independent predictors of increased mortality included presence of DM prior to transplant [aHR (95%CI)=1.194 (1.105–1.290)] and developing post-transplant DM [aHR =1.067 (1.022–1.115)]. Donor’s history of DM was also independently associated with higher mortality [aHR =1.106 (1.022–1.194)]. Furthermore, donor’s history of DM was associated with an increased risk of LT graft failure [aHR =1.351 (1.240–1.471)].

Conclusions: Presence of DM in recipients prior to or after liver transplantation as well as presence of DM in organ donors are associated with an increased risk of mortality post transplant.

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INCREASED GRAFT FAILURE WITH DONATION AFTER CARDIAC DEATH VERSUS DONATION AFTER BRAIN DEATH GRAFTS IN LIVER TRANSPLANT RECIPIENTS WITH HEPATITIS C: AN UPDATED META-ANALYSIS
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Background and Aims: Donation after cardiac death (DCD) LT is increasing due to organ shortage. The outcome of using DCD organs in recipients with hepatitis C virus (HCV) remains unclear due to the limited experience and number of publications addressing this issue. Our objective was to evaluate the clinical outcomes of Donation after Cardiac Death (DCD) versus Donation after Brain Death (DBD) in HCV-positive patients undergoing liver transplantation (LT).