An ELTR study has showed that liver graft preservation with HTK is an independent factor of graft loss after liver transplantation(1). To confirm this result, the analysis was repeated using propensity score-matching for baseline demographics. Univariate, multivariate and Kaplan-Meier analyses were repeated on propensity score-matched patients. Patients were paired on a 1:2 ratio [HTK (n=4964): Other solutions (n=9928)] according to items with similar values. The propensity score was based on recipient gender, period of study (2003-2007 vs 2008-2012), recipient HIV status, recipient age $\geq$ 60 yrs, urgency, hepatocellular carcinoma, donor age $\geq$ 55 yrs, cadaveric full size graft, ABO compatibility, total ischemia time $\geq$ 6hrs and centers performing more than 10 living donors.

Overall, 1, 3 and 5-year graft survival were lower with HTK (78%, 69% and 69%, respectively) compared to the grouped other solutions (83%, 75% and 70%) (p<0.0001).

Multivariate analysis identified HTK as an independent factor of graft loss (RR=1.28, p<0.0001), with other factors as: UNOS status 1 (RR=1.66, p<0.0001), recipient HCV (+) (RR=1.42, p<0.0001), total ischemia time $\geq$ 12 hrs (RR=1.37, p<0.0001), donor age $\geq$ 65 yrs (RR=1.34, p<0.0001), no cadaveric full size graft (RR=1.29, p<0.001), recipient HBsAg (-) (RR=1.22, p<0.005), recipient age $\geq$ 60 yrs (RR=1.21, p<0.0001), no identical ABO compatibility (RR=1.19, p<0.01), male recipient and main disease other than cirrhosis (RR=1.11, p<0.01).

In conclusion, the finding in our recent publication(1) stating that HTK is confirmed to be an independent risk factor of graft loss in liver transplantation.