

Alcoholic Hepatitis and Liver Transplantation

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Some authors affirm that early liver transplant (LT) provides excellent short-term survival in patients with severe alcoholic hepatitis (SAH) (1–4) and similar rates of alcohol relapse compared to patients with 6 months of abstinence. We agree with the choice of not excluding patients who manifest their decompensation with bleeding and infections (common complications of SAH) and patients with psychiatric comorbidities. Data from the literature have stated for a long time that the approach to patients with alcoholic liver disease (ALD) should be changed with no ethical or technical preconceptions. The reasons in favor of this change are as follows:

- 1) ALD is common: it is responsible for 80% of deaths from liver disease and 50% of deaths from cirrhosis (5).
- 2) It is the second cause of LT, and with the arrival of direct-acting antiviral drugs, it will become the primary cause.
- 3) Relapse post-LT varies from 11% to 50%, but a loss of graft occurs in less than 17% of cases and death in less than 5% of cases (6).
- 4) Mathurin et al. (1) have brought an innovation to LT indication: 26 patients were listed for LT (average age 47.4 years), who had not responded to steroidal therapy (average time 13 days). Six-month survival was 77% (compared with 23% in a nonrandomized case-matched control group). It is important to also remember the experience of Singal et al. (7). They first compared the

survival of post-LT patients with alcoholic hepatitis (11 cases, days waiting for LT 67 ± 86) and of patients with alcoholic cirrhosis (35 cases, days waiting for LT 145 ± 340). The 5-year graft and patient survival of alcoholic hepatitis were 75% and 73% ($P=0.97$), and for alcoholic cirrhosis it was 80% and 78% ($P=0.90$), respectively.

We have experience of seven nonresponder patients (median age 49 years), with clinical evidence of SAH and type 1 hepatorenal syndrome, receiving a transjugular intrahepatic portosystemic shunt and then being successfully transplanted. SAH was histologically diagnosed in the removed liver. No patients had an alcoholic relapse post-LT (8). We think that LT indication without the 6-month rule should also be extended to patients with progressive end-stage liver disease (ESLD) who come to the transplant team for the first time and who do not improve after a 3-month abstinence period.

In 2014, an Italian position statement (6) suggested proposals to ensure the right balance between ethics and clinical success (9–12). The proposals in relation to the complex population of ALD patients are as follows:

- 1) Patients with SAH can be placed on an LT list if it is their first episode, if there is no response to medical therapy with steroids, and if family and environmental supports are available.

- 2) Patients with progressive ESLD (a model ESLD score [MELD score] equal to or greater than 19) may be placed on the list if after 3 months of abstinence there is no clinical regression.
- 3) Patients with a MELD of <19 and who have been treated at an alcohol rehabilitation center for some time must ensure 6 months of abstinence.

From these proposals, it becomes clear that the “6-month” rule should not be considered as dogmatic. However, for the optimal management of these patients, a change of hepatology services is needed. Patients, in fact, are affected by a double pathology: alcohol dependence and ALD. Patients should be seen in a nonjudgmental environment made up of professionals with appropriate psycho-relational skills. This provides a closer adherence to the path of care and greater motivation for abstinence from alcohol, both pre- and post-LT.

Collaboration with self-help groups (SHGs) is necessary, particularly during the post-LT period, to ensure abstinence. However, in a multidisciplinary team, the presence of an addiction specialist and a hepatologist with well-defined alcohol experience is needed.

Addolorato et al. (13) suggested how the presence of an addiction unit could be useful. This allows the addition of patients onto an LT list independently of the 6-month abstinence period with a reduction in deaths caused by a wait that is sometimes too long in relation to their serious medical conditions.

Therefore, even though ALD is a self-inflicted pathology, in a society that promotes the consumption of alcohol in relation to success, sport, and well-being, we have a duty to ensure patient care. A new way of working in managing patients with alcohol dependence and liver pathology is needed. During the post-LT phase in particular, the patient must be surrounded by a network of protection where health practitioners and families cooperate closely with the indispensable actions of SHGs. This allows the avoidance of alcoholic relapse in a high percentage of cases and, therefore, indirectly the preservation of the graft. In addition, during the post-LT period, adequate treatment of metabolic syndrome (MS) and close oncological surveillance are necessary. Cardiovascular complications and tumors are the most frequent causes of death in transplant patients with ALD. One year post-LT, 90% of cases develop at least one factor of MS (obesity, hypertension, dyslipidemia, or hyperglycemia); on the contrary, alcohol-related oncological risk decreases by about 10% per year (14). Ethanol, in fact, has been placed in Group 1 by the International Agency for Research on Cancer (IARC)—World Health Organization (15).

In conclusion, according to Lee et al. (4), it is necessary to validate models that can help us predict eventual alcoholic relapse post-LT, and it is even more important to review hepato-alcoholological activity in transplant teams.

Conflict of interest

The authors declare no conflicts of interest with respect to research, authorship, and/or publication of this article.

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