ONE-PAGER FOR ALCOHOL-RELATED LIVER DISEASE YOU MAY USE TO IMPROVE YOUR PATIENT'S LIVER HEALTH

INTRODUCTION

The initial management of patients with high-risk alcohol consumption should focus on alcohol withdrawal, patient/family support, and prolonged abstinence (at least for 3-6 months). This is best provided through the patient's primary care provider with available supports in the community**. Referral to a hepatology specialist prior to recognition and control of alcohol use disorder is not necessary since there is very little we can do to help your patient**. Many primary care specialists and all addiction medicine specialists have expertise in dealing with substance (including alcohol) use disorders. Many patients have an anxiety disorder that they control by self-medicating with alcohol. If your patient has an anxiety disorder, they can be treated with medications and/or psychotherapy including cognitive behavioral therapy.

Please assess your patient's alcohol consumption and potential alcohol use disorder to quantify his/her risk for complications from alcohol involving every organ system (the liver is not the only organ that is affected by alcohol). See Canadian Centre on Substance Use & Addiction website (https://ccsa.ca/sites/default/files/2023-05/CGAH-Drinking-Less-is-Better-en.pdf). You may also consider referral to:

(a) 811-line for addiction support
(b) Alcoholics Anonymous (https://www.aahalifax.org)
(c) Mental Health and Addictions Support through Nova Scotia Health (https://mha.nshealth.ca/en)

INITIAL INVESTIGATIONS

- Screen for viral etiologies affecting the liver with Hepatitis B surface antigen, and Hepatitis C antibody.
- Test for treatable genetic disorders such as hereditary hemochromatosis by checking % iron saturation and HFE gene testing if % iron saturation is greater than 45% AND ferritin above 1,000 ug/L.
- If your patient's age is less 45, assess for Wilson's disease by checking serum ceruloplasmin and serum copper.
- Arrange liver focused abdominal imaging if not done within the last 5 years and consider repeating it if there is a new onset jaundice. If a worrisome hepatic lesion is noted, please refer to one of our four hepatobiliary surgery colleagues at the QEII Health Sciences Centre in Halifax.

ADDITIONAL INTERVENTIONS

Calculate BMI since high BMI is a co-factor in the progression of liver disease due to alcohol; Note that metabolic syndrome can lead to progressive liver disease on its own even after abstinence from alcohol. Manage high BMI with weight loss (at least 7-10% from baseline), exercise, and control of all comorbidities including diabetes, hypertension, and hyperlipidemia).

TIMING OF REFERRAL TO HEPATOLOGY SPECIALISTS

1. After 3-6 months abstinence from alcohol, if your patient's health does not improve or deteriorates with development of clinically significant ascites (due to cirrhosis) in spite dietary 1.5g sodium restriction and initiation of combination of spironolactone and furosemide, or if they have moderate to severe liver dysfunction (INR greater than 1.7 off warfarin/DOACs and/or total bilirubin higher than 50 umol/L) for more than 1 month.
2. If your patient has treatable liver disease including viral hepatitis B or C, hereditary hemochromatosis, Wilson's disease, or one of the immune-based liver diseases like autoimmune hepatitis, primary biliary cholangitis or primary sclerosing cholangitis, you may consider referral as soon as alcohol withdrawal symptoms are controlled, and your patient's social determinants of health have been stabilized/optimized.

The article titled CIRRHOSIS: DIAGNOSIS AND MANAGEMENT published in the American Family Physician journal is an excellent resource https://www.aafp.org/pubs/afp/issues/2019/1215/p759.html1 . In some patient you may consider a telephone review with hepatologist for specific question(s) through VirtualHallway.ca

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