POTENTIAL BARRIERS TO LIVER TRANSPLANTATION IN ALCOHOLIC LIVER DISEASE FACED BY DISTRICT GENERAL HOSPITALS IN THE UK

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INTRODUCTION

Alcoholic liver disease is now the most common indication for liver transplantation in the UK. However there is generally a low rate of liver transplantation; this is despite the fact that the survival after transplant for alcoholic liver disease can be similar to transplant for other indications. It is thought that this reflects the reality that alcoholic liver disease raises issues and controversies not seen with other indications for liver transplant. District hospitals play a vital role in determining whether patients are appropriate for referral to a tertiary centre for liver transplantation. Recommendations are in place to offer guidance in this, however the evidence for some of these have recently come into question. In this article, current guidelines and the evidence behind them will be discussed, with a view to highlight problems faced by district hospitals in the referral of patients with alcoholic liver disease for transplantation.

ALCOHOLIC LIVER DISEASE IN THE UK

Alcoholic liver disease in the UK is on the rise, with the number of people admitted to hospital with alcoholic liver disease in England doubling in the last 13 years (1). As mentioned, it is now the most common indication for liver transplant in the UK. For patients of alcoholic hepatitis admitted to hospital the outlook is poor, with a four week mortality of 50%. Liver transplant is the ultimate therapeutic option; however the rates of transplant are generally very low in this population of patients. There are two factors that may be contributing to this problem. The first relates to the bias faced by patients with alcoholic liver disease, and the second reflects strict guidelines
outlining criteria for the referral of patients to tertiary centres for consideration of transplantation.

BIAS TOWARDS PATIENTS WITH ALCOHOLIC LIVER DISEASE

It is suggested that there may be an element of bias when it comes to managing patients with alcoholic liver disease. Issues and controversies not seen with other indications for transplant are raised, mainly based on the perception that the disease is self-induced. There is also a belief that the recipient is likely to return to pattern of drinking that will damage the graft – although evidence suggests that this is not the case, with fewer than 10% returning to drink more than 21 units per week (2). The result of such prejudice is that patients are discriminated against, with respect to their access to liver transplantation services. Recent research from the USA has suggested that alcoholism is a negative factor in determining patient’s access to information and evaluation for a transplant (3).

CURRENT GUIDELINES

When faced with managing a patient with acute alcoholic liver disease, recommendations provide guidance as to whether or not referral to a tertiary centre for transplantation is appropriate. The team must be confident that:

- there is a potentially reversible element to the disease following alcohol abstinence
- the alcoholic liver disease is associated with alcohol dependence – can this be managed adequately to achieve abstinence (4)
- there are no other co-morbid alcohol related illnesses that will jeopardise the outcome

The UK liver transplant group state that transplantation is only indicated if patients have met the following criteria:

- Enforced and supervised period of abstinence in the community prior to transplantation – 6 months
- Ongoing participation in formal alcohol treatment programme
- Presence of adequate support as determined by social services and psychiatry consultants

Such guidelines are set on the basis that for the graft to be successful, the patient must refrain from returning to alcohol post-transplant. Poor outcomes
have been associated with repetitive episodes, >2, of non-compliance with medical care, and a return to drinking following full professional assessment and advice.

**SIX MONTH ABstinence – IS THERE SUFFICIENT EVIDENCE?**

This is one of the main selection criteria employed by transplant units, however the British Society of Gastroenterology lists it as a “desirable but not mandatory” (5) criteria. This reflects the fact that evidence for this guideline has been difficult to establish.

However, it remains a practical parameter when assessing candidates for transplantation for a number of reasons. It is a numerical value that can often be established with reasonable confidence, which enters potential recipient into a contract with the transplant programme. It also enables some to recover medically such that assessment for transplant becomes unnecessary. Relapse has been found to be associated with shorter periods of pre-transplant abstinence (6), and ultimately it allows time for support measures to be put in place to assist the patient post transplant that have previously been highlighted as vital for the success of ensuring abstinence post-transfusion.

However, evidence to support this guideline as a predictor of outcome has been the subject of much debate. In one meta-analysis, 9/11 studies examining duration of pre-operative abstinence did not find it a useful predictor of ongoing sobriety (7). It has been suggested that it may be a disadvantage to candidates with severe disease who do not have time to participate effectively in rehabilitation. Furthermore, does it truly identify the relapse group without inappropriately discriminating against those who will remain abstinent? There has been a call for more distinction between poly-substance use and those with isolated alcohol addiction when assessing patients for transplantation (8).

**THE PROBLEMS THIS PRESENTS TO DISTRICT HOSPITALS**

All this raises the question: should there be such a strict cut off for abstinence, or should decisions be made on a more individual basis? Criteria for referral to tertiary centres for transplant are of course important for providing guidance to health care professionals referring patients requiring transplantation. However to set a limit of six months abstinence before a patient will be considered for transplantation may be preventing district hospitals from assessing patients on a more individual basis and ultimately preventing a potentially treatable proportion of patients with alcoholic liver disease from receiving the medical care they are entitled to.
REFERENCES


