



Approach to liver transplantation of alcohol related ESLD patients

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Alcohol related end stage liver disease is becoming the leading indication to Liver Transplantation in most EU regions. A close collaboration between mental health specialists and hepatologists is crucial.

Despite the consistent increase in the number of transplantation procedures for alcohol-related liver disease, this indication has always been viewed with prejudice and is often influenced by moral judgments with the disease still being considered as self-inflicted. Thus, access of patients with alcohol-related liver disease to liver transplantation remains marginal. It has been estimated that less than 5–10% of potential candidates with alcohol use disorders (AUD) are eventually listed.

When treating patients with AUD, hepatologists are often unaware that patients with AUD have a high prevalence of psychiatric disorders. Depression, anxiety and affective disorders which represent the mental substrate upon which environmental triggers may lead to alcohol abuse. These triggers are heterogeneous with conflicts within the family, abuse and family loss being among the most frequent. When the above mentioned predisposing psychiatric conditions interact with environmental triggers, alcohol becomes a self-medication which helps patients control their profound suffering and sadness. Being aware of these associations is crucial for hepatologists and a consultation with a mental health specialist should be integral part of the management to effectively support patients with AUD. A mental health problem, in fact, is present in more than 50% of subjects with AUD and its correct diagnosis and treatment is the most effective way to help patients to abstain from alcohol abuse.

These concepts become even more critical when selecting patients for liver transplantation. Most liver transplant programs require a period of abstinence from alcohol before patients are added to the waiting list and, the so called '6-month rule' is still widely used. While evidence that the 6 month-rule alone is a good predictor of alcohol relapse is quite scarce, it is important to highlight that having patients wait for a few months before listing has otherwise at least 2 additional advantages: 1) it allows the identification and treatment of the frequently associated psychiatric co-morbidities. 2) some patients may improve their clinical condition with abstinence with liver transplantation becoming unnecessary.

It is now clear that the '6 month' abstinence rule alone, is inadequate and specifically not applicable in urgent conditions, as is the case of patients with alcoholic hepatitis, where a decision on whether or not to list a patient for LT needs to be taken over a very short time frame. To substantially improve the prediction of alcohol relapse after LT, recent studies have proposed other predictors of relapse beyond the duration of abstinence with the following issues being specifically relevant:

- the identification of treatable psychiatric disturbances
- a history of rehabilitation failure
- a condition of social isolation or absence of family support
- a family history of alcohol use disorder
- dependence on other substances.
- evidence of impairment of neurocognitive function by means of neurocognitive tests

Finally, it is essential to be aware that suffering from AUD does not only negatively affect the health state of the patients, but also their social, educational and occupational functions. All these domains are carefully considered by mental health specialists when evaluating patients with mental illnesses and the 'Global Assessment of Functioning' or GAF is part of their daily practice. As hepatologist we should take advantage of this approach and a close collaboration with our mental specialists would be the most appropriate way to decide when the chance of a liver transplant to the more fragile patients with AUD should be declined. Briefly, the GAF is a number between 0 and 100 that summarizes the clinician's view of the patient's current degree of impairment in terms of psychosocial and occupational or educational function. Generally, normal function is coded in the 70-to-100 range, mild impairment falls in the 70-to-80 range, and moderate impairment is assigned a number between 60 and 70. Severe impairment is coded as 50 and below; higher levels of psychiatric support (such as intensive community-based treatment, residential settings, or inpatient hospitalization) are often required as function drops further down the scale.

In conclusion, it is increasingly recognized that a comprehensive analysis of all these factors by a dedicated mental specialist is required to provide the most reliable selection for listing patients with AUD for liver transplantation.