

UK Liver Transplant Group Recommendations for Alcohol-related Liver Disease

Hepatologists from the seven designated liver transplant centres within the United Kingdom met to discuss various issues relating to liver transplantation and alcohol-related liver disease. Alcohol specialists from the Royal Free, Birmingham and Edinburgh Units were also present. The aim of this meeting was to standardise criteria that would be accepted by the UK liver transplant units for assessment, listing and follow-up of patients where alcohol had contributed to the liver disease requiring assessment. It was hoped that this would contribute to equity of access to transplantation throughout the UK although it was recognised that more work was required to ensure clinicians in secondary and primary care referred patients appropriately.

ASSESSMENT

Patients admitted for assessment where alcohol has contributed to their liver disease should be assessed by a specialist in substance misuse. This specialist should have dedicated time designated for this purpose and it is recommended that resources be allocated to permit this if not already instituted. This assessment should include careful attention to risk factors associated with predicting a relapse to drinking and advising the transplant team on follow up requirements to prevent this

At present, there is conflicting evidence that a fixed period of abstinence will predict compliance post transplant. However, it is important to recognise that with abstinence, many possible candidates will improve to such an extent that transplantation is no longer indicated. A period of abstinence is also required to allow the addiction team to assess the patient and organize any support measures that may be required.

CONTRA-INDICATIONS TO LISTING

It was agreed that there were several factors, each of which, precluded listing for a transplant because a poor outcome for the graft was likely.

1. Alcoholic hepatitis- clinical syndrome of jaundice, coagulopathy rather than histological diagnosis
2. Repetitive episodes (more than 2) of non-compliance with medical care where there was not a satisfactory explanation. This should not be confined to management of their liver disease.
3. Return to drinking following full professional assessment and advice (this includes permanent removal from the list if found to be drinking while listed)
4. Current illicit drug use (except occasional cannabis use)

Use of predictors to identify patients who are liable to drink following transplant was not considered appropriate at present because of the weak, inconsistent evidence base and the fact that most patients who drink following transplantation do so without harm. It was agreed that further evidence was required, with a UK cohort, to identify factors that reliably predicted a poor outcome in terms of graft function and survival.

Robust criteria for predicting a return to heavy drinking (and its consequences on graft function and with compliance) must

1. discriminate consistently and be clinically meaningful
2. be objective and measurable
3. be fair
4. cannot be, or unlikely to be, modified

AGREEMENT

If the opinion of the multi-disciplinary team is that the patient should be listed then the patient will be asked to sign an agreement that they will not drink post transplant and will comply with follow-up.

FOLLOW-UP

The expectation is that all patients who are transplanted for alcoholic liver disease will remain abstinent following liver transplantation. To encourage this, follow-up for alcohol use will be separate from and additional to the transplant follow-up and should be carried out by specialists in substance misuse. Ideally this would be the same individual/s that were involved in assessment. It is anticipated that as time from the liver transplant increases frequency of follow-up will decrease, and that shared care arrangements with alcohol services in the patient's locality will often be appropriate. The type and frequency will depend on the patient's needs.

DEFINITIONS OF RETURN TO DRINKING

To aid audit purposes the following definitions were agreed for relapse drinking.

Nil

Occasional drinking- <2 units per week

Regular drinking- > 2 units weekly

Harmful drinking- graft dysfunction related to alcohol or non-compliance

other demonstrable physical, mental or
social adverse consequences of drinking

AUDIT

This should be regarded as an important part of liver transplantation for alcohol-related liver disease. Only half the units have personnel at present that could help fulfil this role at present. A national audit of listing and outcome would be desirable.

ALCOHOL AS A CO-FACTOR

The same process of assessment and listing should be applied to patients where alcohol has contributed to the progression of another chronic liver disease. This is definitely the case if alcohol consumption >100 units per week and very likely to be the case if consumption lies between 50-100 units. A separate agreement indicating alcohol as a co-factor should be used.

SECOND OPINION

As with all potential transplant candidates, if a possible recipient is found by the multi-disciplinary team not to be a suitable candidate then the opportunity for a second opinion from a second liver transplant unit should be offered. This should initially be in the form of a case notes review with full re-assessment to follow if appropriate.

LIVING- RELATED LIVER TRANSPLANTATION

This procedure is offered only to recipients eligible for a cadaveric graft. The above criteria therefore should be applied to all potential recipients regardless of the availability of a potential donor.

ADVICE TO RECIPIENTS WITH HEPATITIS C

As alcohol contributes to the progression of hepatitis C recurrence it is expected that all recipients with chronic hepatitis C, irrespective of whether they have misused alcohol or drunk normally, should ensure that their alcohol consumption remains within safe limits. As these limits are unknown, the safest approach is to advise all such patients to abstain totally from alcohol.

ADVICE TO OTHER RECIPIENTS

Available evidence and clinical experience suggests that a liver allograft is more susceptible to alcohol injury and therefore the following recommendations are given for recipients not transplanted for alcoholic-related liver disease or those with hepatitis C infection.

Male recipients- a maximum of 3/4 units on one day
two alcohol free days per week

Female recipients a maximum of 2/3 units on one day
two alcohol free days per week