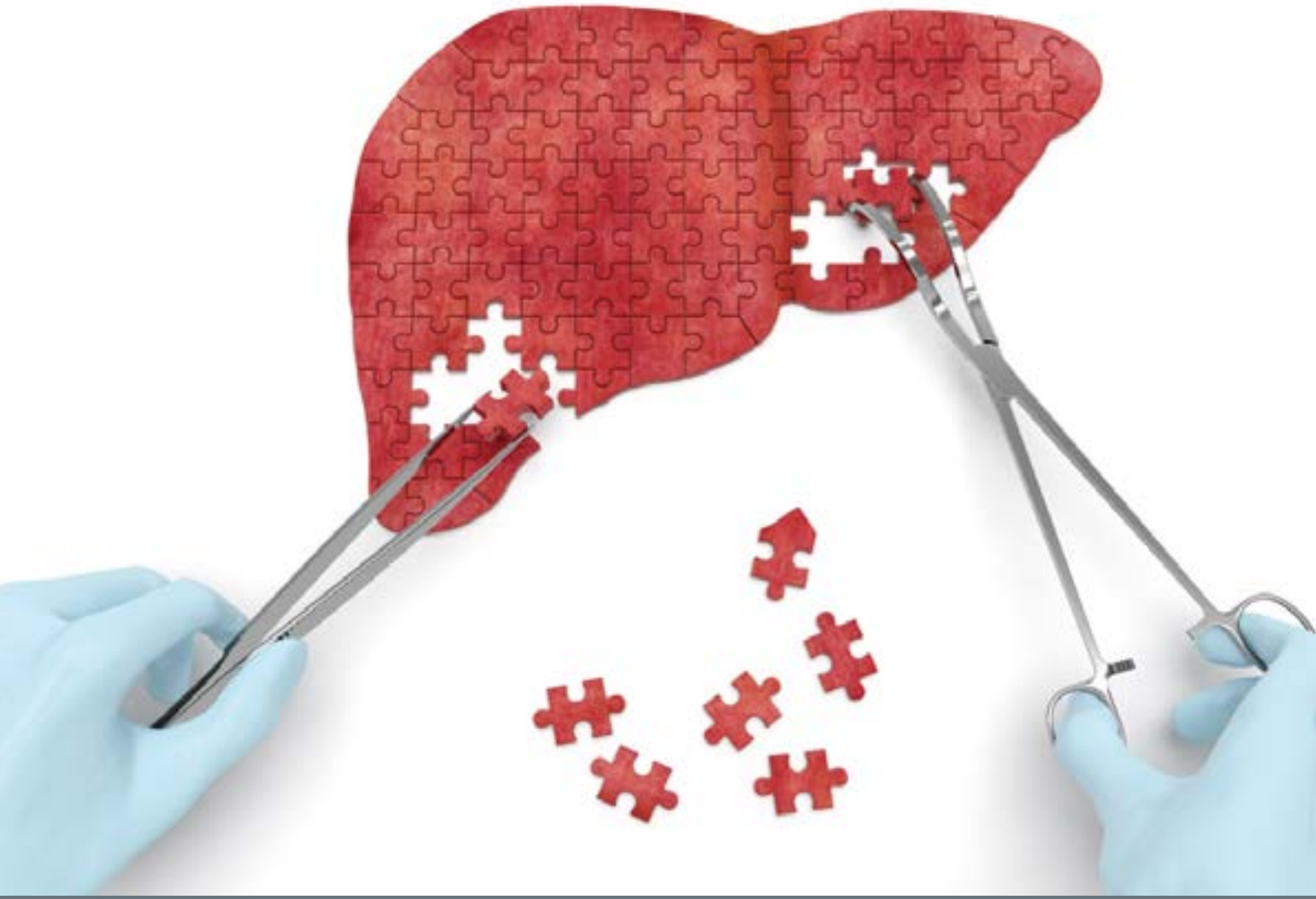
Alcohol-related Liver Disease: Guidance for Good Practice



SHAAP

SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS

www.shaap.org.uk

Background

A major healthcare goal of the Scottish Government is to reduce alcohol-related harm, in all its many manifestations. However, much of the cost, morbidity and mortality of alcohol-related disease is driven by alcohol-related liver disease. SHAAP has convened a multi-disciplinary group of healthcare specialists to devise Good Practice Guidance, aimed at improving and standardising the level of care delivered for individuals at risk of and for patients with alcohol-related liver disease nationwide.

Liver disease is the fifth largest cause of death in the UK with the average age of death being 59 years in contrast to cardiovascular and respiratory disease, where the average age of death is nearly 80 years, making liver disease the third main cause of premature death in the UK. In Scotland this has equated to a rise in the death rates from chronic liver disease with 821 deaths in 2014, more than double that reported thirty years earlier and double what is recorded in England. Additionally, mortality rates vary across the country ranging from 9.1 per 100,000 population in Dumfries and Galloway to 21.5 per 100,000 population[1] in Greater Glasgow and Clyde. These rates are also linked to social deprivation[2] with those living in the most deprived areas having an eleven-fold increase in risk of death from liver disease in comparison to an individual in the least deprived areas.

This is compounded by the five-fold increase in cirrhosis development in 35–55 year-olds over the past decade, which increases the risk of early death. Seventy per cent of UK hospital admissions for cirrhosis have alcohol as a major contributing factor. In the UK the past two decades have demonstrated a significant increase in the prevalence of chronic liver disease. The majority of this is due to alcohol-related liver disease as well as Hepatitis C and obesity-related liver disease.

In view of the fact that 70% of liver cirrhosis is a consequence of alcohol, it is worthwhile highlighting that easy access to alcohol in terms of number of premises, days and hours of sales, and availability in terms of area (m^2) of shelf space devoted to alcohol all contribute to higher alcohol consumption. There should be a stronger pressure on licensing boards in areas where there is documented evidence of alcohol-related morbidity and mortality to restrict the growth of alcohol retailers.

Newsagents, takeaways, libraries, cinemas, theatres, cafes and sport clubs all now commonly apply for licences to sell alcohol. In addition, the overt display of alcohol consumption in our high streets and shopping centres due to the growth of pavement cafés and external drinking areas makes it very difficult to avoid exposure to areas where alcohol is consumed. As a society we are becoming de-sensitised to the ubiquitous presence of alcohol in our shopping and leisure activities.

A survey of Liver Services in Scotland published in 2013[3] has demonstrated considerable variation between Scottish hospitals in the services available for patients with alcohol-related liver disease. Many people who access health services are not routinely screened for alcohol problems and many who attend alcohol services are not being screened specifically for liver damage. The treatment and care delivered to individuals admitted to general hospitals with alcohol-related liver disease is variable, including not receiving appropriate follow-up to ensure their longer-term health. Equally, opportunities are missed to intervene when patients with alcohol-related liver failure have contact with hospital services for other reasons, whether related to alcohol or not. These are missed opportunities, which add up to lives lost. The UK-based NCEPOD report on alcohol-related hospital admissions[4] has highlighted a significant variability in practice with subsequent impact upon response to treatment and long-term survival rates, which are good following an episode of alcohol-related liver disease if the patient does not relapse back into harmful drinking. Complete abstinence from alcohol is usually necessary for optimum recovery.

The process for compiling this Guidance

The Guidance was put together by a writing group comprised of health professionals specialising in liver care and/or public health. The group met on a regular basis and corresponded by email.

Members of the writing group:

- **Professor John Dillon** Consultant Hepatologist and Gastroenterologist, NHS Tayside, and Professor of Hepatology and Gastroenterology, University of Dundee

1 **www.scotpho.org.uk/health-wellbeing-and-disease/chronic-liver-disease/data/mortality**

2 Bellis MA, Hughes K, Nicholls J, Sheron N and Jones L (2016) The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals, *BMC Public Health* 16:111–121

3 MacGilchrist, A (2013) Survey of liver services in Scotland **http://ssg.rcpe.ac.uk/sites/ssg/files/documents/survey%20of%20liver%20services%20in%20Scotland.pdf**

4 National Confidential Enquiry into Patient Outcome and Death (2013) Measuring the Units: A review of patients who died with alcohol-related liver disease **www.ncepod.org.uk/2013report1/downloads/MeasuringTheUnits_FullReport.pdf**

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To ensure the Guidance is representative of physician and patient needs, a consultation event was held in Edinburgh on 23rd June 2016. At this event, the Guidance was discussed and participants were asked to vote on each recommendation using an electronic system. All of these recommendations were carefully re-considered while redrafting the Guidance. The consultation event was attended by a wide range of stakeholders including medical practitioners, third sector organisations, service users/patients and Scottish Government officials. A full list of invitees can be found in Appendix 3.

The consultation event was followed by a period of follow-up where attendees were given the opportunity to consider and offer further comment on the Guidance. The Medical Royal Colleges provided input through SHAAP.

This Guidance has been timed to inform the Scottish Government's 'refresh' of its national alcohol strategy and Ministers and civil servants have welcomed the process.

Evidence

The actions and recommendations contained within this document are based on evidence that: alcohol interventions reduce alcohol-related harm, alcohol causes liver damage, abstinence from alcohol prevents liver damage, and that alcohol-related liver disease disproportionately contributes to the mortality, morbidity and costs of alcohol-related harms.

First, the recommendations are based on the evidence for the impacts and benefits of interventions for the treatment of patients who consume hazardous levels of alcohol. There is clear evidence assessed by NICE[5] that for non-dependent drinkers, brief interventions for alcohol are highly effective and cost-effective in reducing alcohol consumption and alcohol-related harm. In the case of dependent drinkers, it is generally accepted that complex multi-partner agency interventions reduce alcohol consumption and alcohol-related harm. This is government-funded activity that has long been an established principle of the treatment and care pathway within the NHS and its third sector partners.

Secondly, the recommendations are based on evidence that excess alcohol causes liver disease in susceptible individuals[6].

Thirdly, there is a large body of empirical evidence that, in those patients who present clinically with alcohol-related liver damage, abstinence or significant reduction in alcohol consumption dramatically improves prognosis, in terms of both survival and consumption of health care resources from further admissions to hospital[7]. Even in patients with cirrhosis, abstinence or significant reduction in alcohol consumption can lead to the liver reverting to a non-cirrhotic state, with a normal (synthetic) liver function.

Fourthly, there is clear evidence that alcohol-related liver disease is a disease with high age-standardised mortality and morbidity with associated excessive health care costs and resource utilisation[8]. In England and Wales, 63% of all alcohol-related deaths in 2012 were caused by alcoholic liver disease. Liver disease is one of the few major causes of premature mortality that is increasing and deaths from liver disease have reached record levels, rising by 20%

5 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence Clinical guideline. Published: 23 February 2011 **nice.org.uk/guidance/cg115**

6 O'Shea RS, Srinivasan Dasarathy, McCullough AJ (2010) Alcoholic Liver Disease, *American Journal Gastroenterology 2010*; 105:14–32

7 Verrill C, Markham H, Templeton A, Carr NJ, Sheron N (2009) Alcohol-related cirrhosis-early abstinence is a key factor in prognosis, even in the most severe cases, *Addiction*; 104(5):768–774.

8 Corrao G, Bagnardi V, Zambon A, La VC (2004) A meta-analysis of alcohol consumption and the risk of 15 diseases, *Prev Med*; 38(5):613-619.

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in a decade[9]. In Scotland, in 2007/8 there was a 400% increase in patients discharged from hospital with alcohol-related liver disease (6,817) compared to 1996[10]. Treatment for alcohol-related conditions in Scotland costs over £1m a day. Further, it has been shown in modelling data that interventions to reduce alcohol consumption in these groups would be highly cost-effective.

Based on these lines of evidence we have drawn the conclusion that prioritising alcohol interventions to those with alcohol-related liver disease and developing approaches that assertively engage patients affected by alcohol-related liver disease would be a highly cost-effective and a lifesaving use of resources.

Aim of this Good Practice Guidance

The aim of this Guidance is to optimise the multi-disciplinary care provided nationally to facilitate improved survival and optimum health in those affected by alcohol-related liver disease. We present high-level actions for implementation across Scotland, prioritising alcohol-related liver disease for intervention by alcohol services and ensuring high-quality acute medical care for patients with alcohol-related liver disease. To complement and underpin these, we present a series of recommendations for an inclusive care pathway for all phases of alcohol-related liver disease.

Action 1

Specialist alcohol services should prioritise patients with evidence of alcohol-related liver damage for intervention. Services should actively, repeatedly and assertively engage with clients with alcohol-related liver damage.

Action 2

Patients admitted to hospital with alcohol-related liver failure should be managed immediately, in accordance with national guidelines, be reviewed by a physician with expertise in liver disease and be engaged with an alcohol treatment service prior to discharge.

Action 3

Health boards and Integrated Joint Boards should facilitate the organisation of services to allow the operation of the care pathway recommendations.

Recommendations for an alcohol-related liver disease care pathway

Section 1: Identification and Early Assessment

Background and rationale

Acute presentation of alcohol-related liver failure is dramatic and frequently fatal; however, this represents the "tip of the iceberg" and there is a large burden of treatable liver disease that is not identified and remains untreated. If identified and treated, progression to liver failure would, in many cases, be prevented. Interventions, both brief and more intensive, to decrease alcohol consumption are effective and reduce progression of liver disease. These are supported and described in NICE technology assessments[11]. This highlights the importance of early identification of vulnerable individuals for early intervention.

Recommendations for GPs

1 In patients with abnormal LFTs or physical signs of liver damage the Fast Alcohol Screening Test (FAST) should be administered to all and they should be advised to abstain.

2 All patients who have a FAST score of 3 or above should receive an Alcohol Brief Intervention (ABI) for alcohol misuse. Dependent drinkers, who can be defined as those with a FAST score >/=8 should be referred for further assessment and management by specialist alcohol services.

3 Men who report drinking over 50 units per week and women who report drinking over 35 units per week should have blood tests performed to assess their liver function, including liver enzymes, platelet count, synthetic liver function (albumin and prothrombin time) as well as a non-invasive liver fibrosis test[12].

4 Patients with abnormal liver biochemistry associated with excess alcohol consumption, which does not improve with three months of abstinence, or patients

9 Academy of Medical Sciences (2004) Calling time: The nation's drinking as a major health issue / BMA (2009) The human cost of alcohol misuse

10 Scottish Government (2008) Costs of alcohol use and misuse in Scotland **www.gov.scot/Resource/Doc/222103/0059736.pdf**

11 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence Clinical guideline. Published: 23 February 2011. **nice.org.uk/guidance/cg115**.

12 See Appendix 1 & 2.

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with elevated fibrosis scores should have a liver ultrasound scan and a full liver screen performed.

5 Those patients above the threshold for fibrosis score, or with an abnormal ultrasound scan or with a positive liver screen for alternative liver diagnoses should be referred to local specialist liver services for assessment.

Recommendations for Alcohol / Addiction Services

This includes addiction services focussing on drug addiction as concomitant alcohol use can significantly worsen outcome.

6 Where alcohol has been identified as a contributing factor, all clients should be offered a test of liver fibrosis at presentation either on-site, by the patient's GP or by another local service provider.

7 Patients above the threshold for fibrosis score, with an abnormal ultrasound scan or with a positive liver screen for alternative liver diagnoses should be referred to local specialist liver services for assessment. The referral should be made by the alcohol service, or they should ensure that another practitioner has done so.

8 Patients with abnormal fibrosis scores should be prioritised for treatment, for treatment intensification and for re-engagement with alcohol services if they default from follow-up and have ongoing problems.

9 Patients with ongoing alcohol use who are still in contact with alcohol services should have a reassessment of liver fibrosis undertaken annually.

10 All staff involved in patient care should have training to increase awareness of symptoms and signs of alcohol-related liver disease.

Recommendations for Acute General Hospitals

This includes all admissions to all hospital departments.

11 All adult patients, irrespective of the reason for assessment and/or admission to hospital, should have a FAST test administered upon admission. The FAST questionnaire should also be included in the assessment documentation for every adult patient admitted to hospital. Alcohol should be considered as a factor in paediatric admissions.

12 Men who report drinking over 50 units per week and women who report drinking over 35 units per week should have blood tests performed to assess their liver function, including liver enzymes, platelet count, synthetic liver function (albumin and prothrombin time) as well as a non-invasive liver fibrosis test[13].

13 All patients who have a FAST score of 3 or above should receive a test of liver fibrosis and an Alcohol Brief Intervention (ABI) for alcohol misuse, even if they have another liver disease. This should be provided in hospital ideally by an alcohol liaison team, but at least by staff able to refer on dependent drinkers to alcohol services.

14 All patients attending viral hepatitis services should have a FAST score and an ABI performed in those with a FAST score of 3 or above.

15 Alcohol should be considered as a possible co-factor for liver damage in all patients with abnormal liver enzymes. All patients attending out-patient services for an assessment of abnormal liver enzymes, regardless of the aetiology, should have a FAST score and an ABI considered for those with a FAST score of 3 or above.

Recommendations for prisons, police custody, mental health services, sexual health services, and any other community settings where health questionnaires or assessments including ABIs are undertaken

16 All clients should be assessed for alcohol harms, by the FAST score.

17 All clients who have a FAST score of 3 or above should receive an Alcohol Brief Intervention (ABI) for alcohol misuse. Dependent drinkers, who can be defined as those with a FAST score >/=8 should be referred for further assessment and management by specialist alcohol services or to their GP depending on local referral protocols.

18 All clients with a FAST score of 3 or above should be offered a test of liver fibrosis at the earliest opportunity (either on-site or by the patient's GP).

19 Clients identified as having alcohol problems and an elevated test of liver fibrosis should be offered an ultrasound scan and be referred to specialist liver services.

13 See Appendix 1.

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Section 2: Treatment of alcohol-related liver failure

Background and rationale

This section is focussed on the acute care of patients with alcohol-related liver disease who have presented to clinical services with signs or symptoms of liver failure. The NCEPOD 2013 report, "Measuring the Units", highlighted improvements that could be made in the care of those requiring an acute hospital admission due to alcohol-related liver disease. This suggested that these could have resulted in reduced mortality and highlighted the standards required to provide good care and prevent avoidable deaths. Following on from this, the British Society of Gastroenterology and the British Association for the Study of the Liver have devised a care bundle incorporating best practices to be completed for all patients presenting with decompensated cirrhosis within six hours of acute admission into hospital. This will guide appropriate care prior to urgent liver specialist review within 24 hours.

Patients with alcohol-related liver disease are likely to have a range of other health needs, including their mental health, which should be managed appropriately.

Recommendations for General Practice/ Hospital Receiving/Assessment Units

20 Patients presenting in general practice or acute admissions units with a history of alcohol problems and who are jaundiced or bleeding require urgent liver specialist assessment.

21 The initial urgent management of patients admitted to hospital should follow a locally adapted version of the BSG/BASL Cirrhosis Care Bundle.

22 The use of the BSG/BASL Cirrhosis Care Bundle and its application to patients should be the subject of regular audit.

23 Patients admitted acutely with alcohol-related liver failure should be reviewed by a service with expertise in the management of liver disease within 24 hours of admission.

24 Patients admitted with alcohol-related liver failure must also be assessed in hospital prior to discharge by an alcohol care team, with planned follow-up. This should include an integrated care pathway utilising a multidisciplinary team including liver and addiction specialists.

25 Decisions about the escalation of hospital level of care for patients with liver failure related to alcohol should be based on severity of the liver disease and the prognosis. Patients must not be denied higher-level care if clinically indicated.

26 Hospital-based alcohol care services should be available seven days a week for those who need them, in line with BSG recommendations[14].

Section 3: Follow-up

Background and rationale

It is vital that individuals with alcohol-related liver disease coming into contact with clinical services or a multi-disciplinary team have a plan for ongoing follow-up and assessment. They remain a high mortality risk irrespective of whether the index contact with the healthcare system is through an acute hospital admission for decompensated alcohol-related liver disease or identification of chronic alcohol-related liver disease by another pathway. This process requires structuring of service provision by responsible health boards to enable cohesive integration of all services that contribute to care, including community and secondary care services. Furthermore, as described in the NICE 2015 quality standard, "Alcohol: preventing harmful alcohol use in the community", this approach is fundamental to reducing harmful alcohol use in the community, preventing premature deaths and improving quality of life for those with long-term conditions.

Recommendations

27 Health boards should ensure structures and clinical teams are in place to detect and deliver the interventions to reduce the impact of alcohol-related liver disease. These should be agreed with all professionals involved.

28 A follow-up plan for alcohol problems should be made for each patient assessed at or admitted to hospital with alcohol-related liver disease.

29 Any patient found to have alcohol-related liver disease with significant fibrosis, however detected, should be followed up by liver specialists and alcohol services or joint clinical services.

30 Follow-up of patients with liver failure related to alcohol and/or alcohol-related liver disease should be holistic and based on an integrated care pathway utilising a multidisciplinary team including liver and addiction specialists.

31 When appropriate, patients with alcohol-related liver failure should be assessed for liver transplantation as per NHSBT's guidelines.

32 There should be a policy of assertively maintaining patients in treatment. Multiple strategies should be used to facilitate and maintain patient engagement with alcohol treatment services.

14 British Society of Gastroenterology (2011) Alcohol Care Teams **www.bsg.org.uk/sections/liver-news/alcohol-care-teams.html**

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Section 4: Recommendations for research

33 Research should be performed to evaluate (including health economics) the most effective means of assessing liver fibrosis in people at risk of alcohol-related liver disease.

34 Research should be performed to discover the most effective way to engage with patients at risk of alcohol-related liver failure as early as possible, so as to prevent harms.

35 Research should be performed to evaluate models of access to alcohol treatment services and treatment options for those with alcohol-related liver failure, especially those who decline to attend services.

Appendix 1

Measures of liver fibrosis

The majority of people with alcohol problems will not have advanced alcohol-related liver disease. In the context of this Guidance it is intended to prioritise patients with liver damage for alcohol interventions to reduce consumption and to identify those patients who should be prioritised for alcohol interventions. To do this we recommend the use of tests of liver fibrosis which are based on markers of fibrosis and damage. Although they have been developed to try and detect cirrhosis of the liver, the aim of this Guidance is to prevent the development of cirrhosis, so we are focussed on those with developing liver damage and targeting them for alcohol interventions. We will use the lower thresholds of these fibrosis markers, which will enable us to identify those who might have liver damage and would be prioritised for alcohol intervention and follow-up. Within the group with raised fibrosis markers there will be a number who have advanced liver disease who will need further specialist assessment according to local arrangements that are already in place for patients with suspected chronic liver disease.

The assessment of liver fibrosis is complicated and is changing with technological advances. There are three types of technologies that allow the estimation of liver fibrosis: scores based on traditional blood tests, scores based on new biomarkers and imaging-based tests. Scores based on traditional liver blood tests are cheap and routinely available, but they lack specificity for detection of cirrhosis and, in alcohol-related liver disease especially, may be over-sensitive, but in the context we intend their use in this Guidance, that is not a disadvantage. Scores based on new biomarkers are available from commercial sources, are more specific and are recommended by NICE for the detection of cirrhosis. These biomarkers are not routinely available anywhere in Scotland and their cost-effectiveness in this context would need to be evaluated. Imaging-based testing such as Fibroscanning or liver stiffness measurement on abdominal ultrasound is the most expensive, and availability across Scotland is limited by capacity and again, the cost-effectiveness of using these techniques in this way requires assessment. It is important to note the emerging evidence that personalised biological information adds to the prevention impact of alcohol interventions and this may be different between the different techniques.

The recommended preferred scores are based on the current evidence, availability of tests, and opportunity cost. The APRI score ((AST/Normal range of AST)/Platelet count X 100) and the FIB4 (FIB-4 = age (yr) x AST [U/L]/ (platelets [109/L] x (√ALT [U/L]), use routinely measured liver function tests. Some laboratories require a specific request for AST, but it is routinely available throughout Scotland and these are very cheap. These scores have been well validated in a wide variety of liver diseases. They may be less accurate in alcohol-related liver disease as alcohol may preferentially increase the AST. However, the result of this is to increase the sensitivity of the test so patients with advanced disease would still be referred for assessment. The recommended cut-offs for identification of patients at risk of fibrosis are APRI score greater than 0.7 and FIB4 greater than 1.45.

Appendix 2

Definition of liver screen

The term ‘liver screen’ is used here to describe a group of blood tests that screen an individual with suspected chronic liver disease for a group of possible aetiologies for that disease. Alcohol-related liver disease would normally be diagnosed in the presence of liver damage, a history of excess alcohol and a negative liver screen.

The tests in a liver screen to investigate chronic liver disease include: viral serology for hepatitis B & C, tests for immunoglobulins and immunology for antibodies to smooth muscle, mitochondria and nuclear factor as well as liver kidney muscle (LKM) for auto-immune liver disease, ferritin for haemochromatosis, alpha 1antitryspin for its deficiency and caeruloplasmin to exclude Wilson’s disease in young patients. Metabolic syndrome (abnormal lipid profile, high blood pressure, obesity and / or diabetes mellitus / insulin resistance) should also be considered in all patients as part of the liver screen. An abdominal ultrasound is usually also performed as part of a liver screen.

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Appendix 3

Invitees to consultation event, 23rd June 2016

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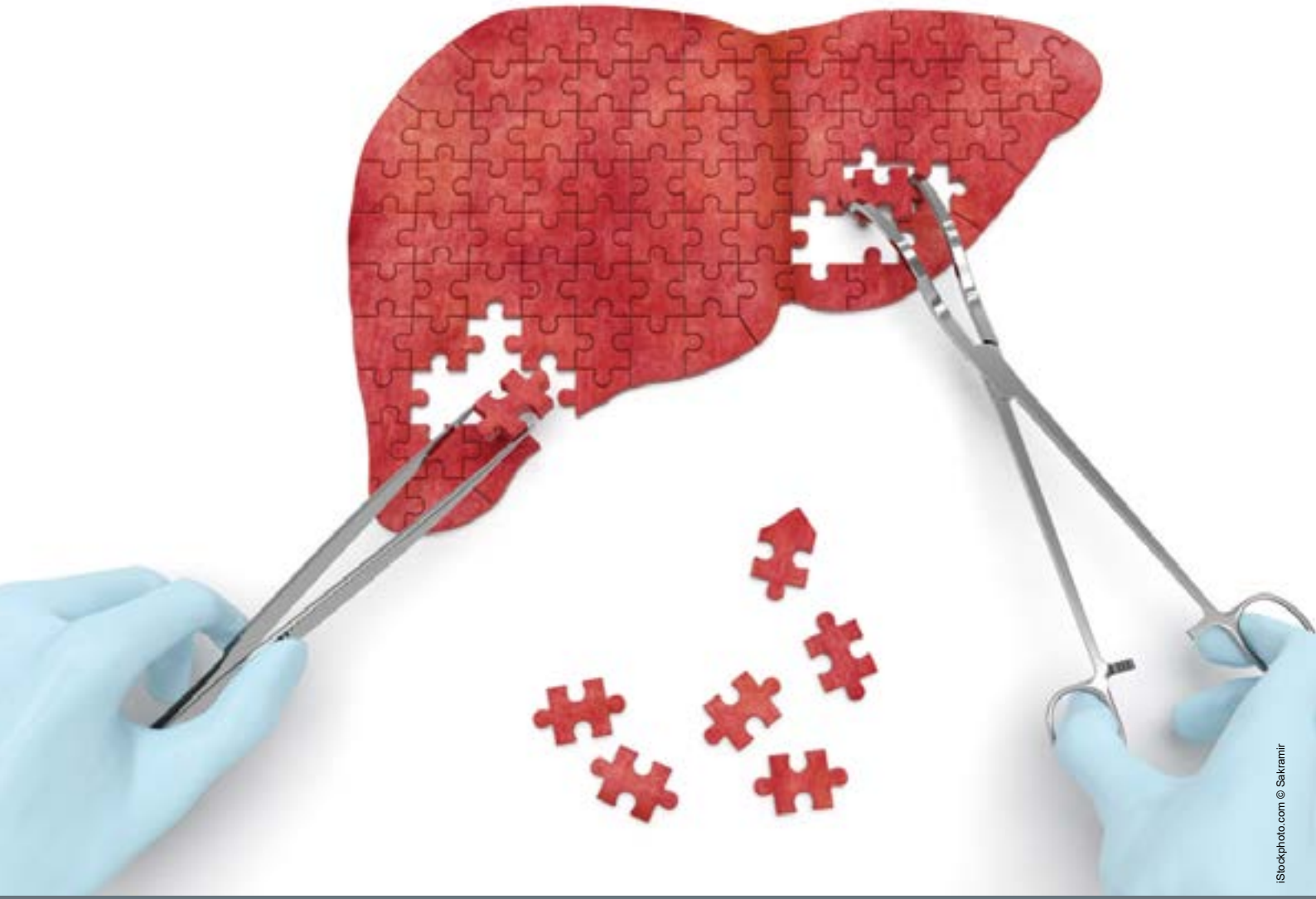

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