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My Patient's At 'Low Risk' for Clinically Significant Fibrosis: What Should I Do Now?

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Eckel:
This is CME on ReachMD, and I'm Dr. Robert Eckel. We're going to discuss what to do with patients who are at low risk for clinically significant fibrotic liver disease.

Let's take a look at a case. I'm describing here, a 59-year-old post-menopausal woman who's referred to you in the endocrinology clinic. Her medical history is one of being overweight for over a 10-year period. She has type 2 diabetes, managed with metformin. She's been hypertensive on 20 mg of lisinopril. And a recent liver B-Mode ultrasound indicated hepatic steatosis. The reason for her visit today was a follow-up appointment to review her most recent laboratory results. Those test results revealed an AST of 40, a bit above the upper limits of normal of 30, and an ALT of 37, upper limits of normal 36. To assess her further, we measured her waist circumference at 38 inches. Her body weight predicted a BMI of 31 kg/m^2. Her blood pressure was 134/78 and her hemoglobin A1c was elevated at 7.4%.

Now based on her labs and her cardiometabolic risk, we went ahead and assessed a FIB-4 score, which is routinely used now to assess the potential severity of their fatty liver disease. And the FIB score was 1.4, with a normal level being up to 1.3 and less than 2 if she's above 65 years of age, and she's a little bit younger than that. So basically, her FIB score was kind of a borderline level, but it indicated a fairly low risk of advanced fibrosis. While a score really above 3, for instance 3.25, should really trigger a referral to a specialist for further evaluation of the liver disease.

We also did a FibroScan, or a measure of liver stiffness. And ultimately, this came out with a level of 7.8 kilopascals, which is an upper limit of normal of 7.9 being elevated. So ultimately, with a more established technique using a vibrating system to really characterize this in more detail, we can get information such as the FibroScan, the VCTE, the vibration-controlled transient elastography, to give us an idea, again, whether her disease is worthy of further consideration at this time, or it's one where we can take a more preventive mode in terms of her approach.

So how would we characterize this patient's risk? Based on the presence of multiple risk factors, she could be considered to have MASLD, again, metabolic-associated hepatitis and liver disease. But based on her FIB-4 and her liver stiffness measurement scores, at this time she's clearly not at risk for clinically significant fibrosis. So we need to take a step back and see how that influences our steps going forward.

Well, she has obesity with a BMI of 31 kg/m^2, and it's absolutely clear that steps need to be taken to modify her body weight. So with lifestyle alone, a weight loss goal should be established at approximately 10% weight reduction. Much less weight reduction may modify liver fat to some extent, but probably is not sufficient to really look at predicting a benefit from the natural history of fatty liver disease

Then for patients with type 2 diabetes, like this woman, a therapeutic consideration could be utilizing pioglitazone, which is now

evidence based to provide benefit, not only to control glycemia, but also to reduce the likelihood of progression of fatty liver disease. In fact, reduce the amount of hepatic steatosis.

But now we're entering an era of new therapies, including GLP-1 receptor agonists, particularly, that result in a substantial amount of weight loss. So I think a big question we have in today's marketplace is whether these drugs being still pretty expensive versus bariatric surgery, which may be equally effective in modifying not only weight but fatty liver disease, is an option to consider for your patients. But with this patient, hopefully weight reduction can follow in the very near future, and then we can repeat this FIB-4 score in 2 to 3 years to evaluate the success of the weight reduction, hopefully on her fatty liver disease.

In addition, I think we need to provide her with education about alcohol avoidance, physical activity, and ultimately support by both the endocrinologist, whom you are, that she's seeing and also the primary care physician. I think, again, referral to the hepatologist should be delayed until the FIB-4 reaches a higher level of concern.

Thank you very much for your attention.

Announcer:
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