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A Look into Liver Transplants

Dr Buch:
What do we need to know about liver transplants? This is ReachMD *GI Insights*. I'm your host, Dr. Peter Buch. Joining us today is Dr. Alan Bonder, who is an assistant professor of medicine at Harvard Medical School and who practices at Beth Israel Deaconess Medical Center.

Welcome back to the program, Dr. Bonder.

Dr. Bonder:
Thank you, Dr. Buch. It's a pleasure to be with you again.

Dr. Buch:
Thank you so much. To start us off, Dr. Bonder, how does survival rate vary depending on the indication for liver transplant?

Dr. Bonder:
So I was just going to start that we really do not mind about the etiology of the liver disease. Our survival, regardless of your underlying liver disease, is pretty good, so we are trying to get patients who have a liver transplant who have a really good quality of life, so when we see patients in our clinics—and I want to quote what's the UNOS, which is our regulator agency asks us to really disclose to patients—so up to one year, more than 95 percent of the patients are alive and doing well, up to three years 75 to 80 percent, and up to five years between 65 and 70 percent, so this is what we quote to patients regardless of your etiology of your underlying liver disease.

Dr Buch:
Great. A lot of folks out there have a question about UNOS, so how does the United Network for Organ Sharing, also called UNOS, work? And please discuss what exception points mean and how that fits in.

Dr. Bonder:
So that's a question that will get different answers. The first one, UNOS is basically the regulating agency that we have in the United States for organ donation. Specifically, in the liver transplant world, UNOS basically has what's called the MELD system. The MELD system is your bilirubin, your creatinine, and your INR, putting in a formula and goes from six to 40, 40 being the sickest, six being the healthiest, so any patient at any given time based on their lab data will have a MELD score in that range.

So in the liver transplant world, we don't have waiting time, for example, like the kidney people do, so we only rely on what the MELD score tells us at that time, so we can have patients who are listed with a MELD of 20, they are being listed for quite some time, meaning six to eight months, and a patient just comes right into the emergency room with a MELD score of 40 gets stabilized and gets a liver transplant, so that's actually how the point system, how the UNOS regulates the liver transplants around the country. And as you mentioned, Dr. Buch, we have what's called exception points, so there are certain diseases that don't get MELD. For example, liver cancer or HCC or portopulmonary syndrome or hepatopulmonary syndrome, those patients really don't have a high MELD, but we know that their liver disease is causing this complication. So in those cases there are certain criteria that we can apply based on UNOS rules, and they get exception points, means they will go up on the list because they have a condition that is related to the underlying liver disease.

So, as just mentioned, liver cancer is the best example. So what we know now is patients who have liver cancer will stay with their natural MELD score, like six or eight. Once they hit that six-month mark, their MELD score will go up to the top of the list, and they can get called for a liver transplant at any time as anyone with a sick and a high MELD will come into our emergency rooms.

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Dr Buch:
And please tell us about the outcomes of donor livers with hepatitis B or C.

Dr. Bonder:
Well, this is a very important question currently. As everyone is aware, there is an opioid epidemic, so with this, the hepatitis C that's out there, it's more prevalent. So most of those donors are young donors that, unfortunately, die with an overdose from opioids, and these are great organs. As far as outcomes, there are really good outcomes as they are not different than someone who does not have hepatitis C. The only thing that is important to mention that patients who get a hepatitis C organ, unfortunately, will get hepatitis C, but fortunately for them, the current therapies are really good at eradicating hep C. Currently, we quote patients that with a first round of therapy, what we have available with the antivirals, you can get rid of the hepatitis C 92 to 93 percent of the times.

As far as hepatitis B, the data is not as clear, although we do have more data from the West Coast in the United States of using hepatitis B organs. The problem with using those organs, you're giving hepatitis B, and with that, you are giving them the risk of having liver cancer, so this is something that we need to discuss with patients. And I think very important to know about, what are the benefits and the risk in that patient population? Because if the patient is really sick needing a liver, maybe that will be the right patient to get one of these organs compared to someone who is not as sick and does not want to use a hepatitis B.

I want to mention that we are listing everyone in our transplant center accepting hepatitis C organs because we do feel that the treatment is so good and so well-tolerated that hepatitis C right now is a treatable condition with three months of therapy. So again, this is really important in our transplant population.

Dr Buch:
Doesn't it ultimately come down to how many patients need the liver transplant and how many livers are available?

Dr. Bonder:
That's correct. It's actually a supply and demand issue.

Dr Buch:
Exactly right. Tell us when you're dealing with hepatitis C in a transplant situation, how does immunosuppression affect the ongoing treatment?

Dr. Bonder:
So with the current treatment, there's really no medication or drug-drug interaction, so I would say it's pretty safe without really giving you any problems with kidney or liver function, so right now, Dr. Buch, I would say that hep C in 2023, it's pretty safe without any major drug-drug interactions in the immunosuppressed patient.

Dr Buch:
And, Dr. Bonder, what should we know about living donor transplantation risks?

Dr. Bonder:
So that's another option. So when we see a patient for a new transplant evaluation, we actually give them the options. I think, as we mentioned earlier, you could be listed at two different regions, but also living donation is another option. The important thing about living donation, the actual donor will go through a same thorough evaluation as the recipient. So it's a big surgery, but in good hands has pretty low morbidity and mortality. I would say less than one or two percent. So it's a great option for patients who basically suffer from a bad disease who don't get MELD points. So it's an option for every patient that's out there, but unfortunately, not every transplant center has a living donor surgeon. So this is a very specialized surgery, and you need to have a lot of specific surgeons devoted to living donors because the importance about living donors is the outcomes of living donation depends on the volume, so the more volume the better you do, and what we've seen in the U.S. and actually more in the southeast countries where most of the living donation is done, is the more volume, the less complications you get.

Dr Buch:
Thank you very much for that one. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Alan Bonder about liver transplants.

Dr. Bonder, moving on to this one, which chronic liver diseases are likely to recur after liver transplantation?

Dr. Bonder:
I would say most of them will recur. So we have right now the most common reason for liver transplant, alcoholic liver disease, and there is unfortunately, high relapse rate, so we are quoting in the literature up to 30 to 40 percent of people will go with some type of nonharmful drinking. In the case of fatty liver, we know that metabolic syndrome does appear as a complication from the medication,

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and as patients get better, improve from their liver transplant, they start gaining weight, so fatty liver is a recurrence. And all out immune liver diseases, autoimmune hepatitis, primary biliary cholangitis, primary sclerosing cholangitis are diseases that can recur up to 20 to 30 percent of the times. So we do monitor them, and if they have specific liver chemistry patterns, sometimes we'll do biopsies, and sometimes we'll do testing to confirm the recurrence of the original disease.

Dr Buch:
And coming back to the UNOS system, when there is recurrence of disease and they need a second or perhaps a third liver transplant, is there a limitation of how far UNOS will go?

Dr. Bonder:
There's a great question, and the answer is no. I mean, we've had patients with PSC needing three livers. We've had patients with autoimmune hepatitis needing three livers. As long as the patient has a really good risk-benefit ratio and also talking with the surgeons because, as you know, if you think about the first hepatectomy being really hard going to a second and a third liver transplant, which can cause a lot of adhesions and a lot of problems removing those livers can be an issue. So the answer to your question, it is possible, but it needs to involve a discussion with our surgeons and with us and with the patients explaining the risk and the benefit. But unfortunately, also, Dr. Buch, the survival that you asked me at the beginning of the conversation is a little bit different. So as you get your second liver, your one-year, your three-year, your five-year survival are less, and if you do a third liver, the one- and three- and five-year survivals are less, so those things also get disclosed to patients when we are looking for a second and a third liver transplant.

Dr Buch:
Thank you. And before we conclude our discussion, are there any additional thoughts you'd like to share with our audience?

Dr. Bonder:
I think one of the biggest things is we need to remove the fear from primary care, even general GI, about taking care of patients with a liver transplant because what we've seen in the liver transplant center is once we transplant them, anything that comes with the liver transplant patient needs to involve the transplant center, which is not true. I think one of the biggest things we need to empower clinicians is just look for the drug-drug interactions. Make sure they're looked at for levels. Make sure they look at creatinines. And always if they have a question, reach out to those transplant centers who are taking care to make sure that the new medications or the new prescriptions that you're sending are the right ones for those patients.

Dr Buch:
What an excellent review on liver transplantation. I want to thank my guest, Dr. Alan Bonder, for sharing his insights.

Dr. Bonder, thanks so very much for joining us today.

Dr. Bonder:
Thank you, Dr. Buch, and I'm happy to talk to you again. And hopefully, we will meet again in the future.

Dr Buch:
Absolutely. For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.

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