Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/screening-for-significant-fibrosis-in-patients-with-obesity/57039/

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Screening for Significant Fibrosis in Patients with Obesity

Announcer:
You're listening to *GI Insights* on ReachMD. On this episode, we'll hear from Dr. Fernando Bril, who's an Assistant Professor in the Division of Endocrinology, Diabetes, and Metabolism at the University of Alabama at Birmingham Heersink School of Medicine. He'll be discussing how to identify clinically significant fibrosis in patients with obesity. Here's Dr. Bril now.

Dr. Bril:
Patients with obesity are at really high risk of clinically significant fibrosis, so it's very important that we screen all patients that have obesity, especially if they have one cardiometabolic risk factor. Guidelines may recommend screening every patient with obesity, but some are a little bit more specific and recommend those with obesity plus one cardiometabolic risk factor—either dysglycemia, high blood pressure, high triglycerides, or low HDL.

But the important concept is that, most likely, all these patients are at increased risk of clinically significant fibrosis, so you need to start screening these patients if you are already not doing that in your clinic.

So how do we do it in clinic? Most guidelines recommend FIB-4 as the first step. FIB-4 is a formula that is based on age, AST, ALT, and platelets. It's easily calculated if you open an app online. The American Gastroenterology Association has an app. MedCalc has a FIB-4 incorporated. So you just need information that you already have available: age, AST, ALT, and platelets. It gives you a number, and the number to remember is 1.3. If the FIB-4 of the patient is above 1.3, then you need to go to the second step of a risk stratification. That would be either vibration-controlled transient elastography or ELF. If it's below 1.3, chances that patient will have clinically significant fibrosis are relatively low.

What guidelines recommend is rechecking FIB-4 in one to two years. I think for me, yearly works nicely, because it goes with all the other labs that I get yearly. I said 1.3 three. Again, there's some discussion as to whether in patients older than 65, we need to use 2 as the cutoff point for FIB-4. That's still under debate, with some guidelines recommending that alternative cutoff point and others just going for a universal 1.3. And remember, it's just a first step, then vibration-controlled transient elastography or FibroScan and enhanced Liver Fibrosis, or ELF, as the confirmatory or second non-invasive test to try to confirm whether patients have clinically significant fibrosis.

Announcer:
That was Dr. Fernando Bril talking about fibrosis screening strategies for patients with obesity. To access this and other episodes in our series, visit *GI Insights* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!

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