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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Treatment Strategies for Nonalcoholic Fatty Liver Disease: Part 1

Dr. Buch:
Welcome to GI Insights on ReachMD. I'm Dr. Peter Buch, and this is Part 1 of a two-episode series focused on treatment strategies for nonalcoholic fatty liver disease. Joining me in this discussion is Dr. Sidney Barritt, who's an Associate Professor of Medicine and the Director of Hepatology at the UNC Liver Center at the University of Northra Carolina.

Dr. Barritt, welcome back to the program.

Dr. Barritt:
Thank you very much for having me, Dr. Buch. I look forward to our conversation today.

Dr. Buch:
Let's dive right in, Dr. Barritt. What clinical tools do you use to distinguish alcoholic from nonalcoholic fatty liver disease?

Dr. Barritt:
So if you were to take a liver biopsy of patients with alcohol-induced liver disease and those with more metabolic-associated fatty liver disease, you'd find that the biopsy findings can be very similar: presence of fat macrovesicular steatosis, inflammation, and varying degrees of scar tissue. So with the biopsy features being very similar, we have to rely on history, and this is where we have to be very careful and very thorough with our patients to take a nonjudgmental and nonthreatening history of their alcohol use. And one, we have to be clear about what alcohol is. Often, if you ask patients if they drink alcohol, they assume that you mean spirits or liquor, but we know that one can of beer, a 12 oz. can of beer, has the same amount of ethanol in it as a 5 oz. glass of wine or a 1¼ oz. shot of liquor or spirits. And we've come up with a line in the sand that distinguishes metabolic fatty liver from alcohol-induced fatty liver. For men, if you drink on average more than two units of alcohol a day or 14 drinks in a week, or for women more than one unit of alcohol a day on average or seven drinks in a week—if you're above that threshold, we call it alcohol-induced fatty liver. If you're below that threshold, we call it metabolic-associated fatty liver or nonalcoholic fatty liver disease.

Dr. Buch:
And are there specific clinical tools that you recommend to our audience to make that distinction?

Dr. Barritt:
Well, it's all about developing a good rapport with your patients and a level of trust. As physicians, we want our patients to know that we're looking out for their best interest, and when we're asking about alcohol or other challenging questions, we need to make sure that we do it in a very nonjudgmental manner, and we try to avoid stigma with addiction with other problems so that our patients feel they can be honest and up front with us.

Dr. Buch:
Do you ever use the CAGE questions, or do you find that too judgmental?

Dr. Barritt:
I'm careful with that. What I try to do is develop a rapport and have a conversation with my patients. It's not the first question that I ask patients. On occasion, I will use a CAGE questionnaire, and in some research settings, we use a little bit longer-form AUDIT questionnaire to ask about alcohol use. CAGE can be useful. It's simple and straightforward. But again, I don't start with that. I may ask those types of questions but sort of weave it in in a way that's not so obvious that that's what I'm getting at.

Dr. Buch:

For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Sidney Barritt about managing patients with nonalcoholic fatty liver disease or NAFLD.

And when suspecting nonalcoholic fatty liver disease, what workup do you recommend?

Dr. Barritt:
So I encounter patients in various degrees of their diagnostic journey. I'll have some patients who are referred to see me because of abnormal liver enzymes that were done during a routine physical, or I'll also see patients who have an incidental finding of fat in the liver on imaging that was done for some other reason.

When I start with patients who show up with an abnormal liver enzyme test, we have to do a rational evaluation for why they have an abnormal liver enzyme test. So any adult over the age of 18 should be screened for hepatitis C, and any adult with abnormal liver enzymes should be screened for viral hepatitis, and we go through sort of other common liver etiologies that we need to exclude because there is no single blood test that makes a diagnosis of nonalcoholic fatty liver disease. But if I have highly suspected nonalcoholic fatty liver disease, meaning that a patient has evidence of fat on imaging, perhaps they have an abnormal ALT, I'll start with using clinical prediction scores to assess disease severity. And the clinical prediction scores that I use most often are the FIB-4 or the NAFLD fibrosis score, and the reason that I use these is because they're effectively free.

The FIB-4 is made up of information that I usually have on hand. It's a calculation that's based on the patient's age, their platelet count, and their AST and ALT levels, and this is put into a formula that generates an assessment of risk for advanced fibrosis or low risk for advanced fibrosis. The NAFLD Fibrosis Score is somewhat similar and again uses information that's effectively free: the patient's age, their BMI, diabetes, an AST to ALT ratio, a platelet count, and their albumin level. And these are reasonably good for ruling in or ruling out advanced fibrosis.

Now, there are a variety of other labs that can be sent off. The Enhanced Liver Fibrosis Test, or the ELF test, was recently approved in the U.S. FibroSURE is available as well too. These are both proprietary tests though that may cost the patient money when you send these tests off to the lab.

If a patient comes back as having low risk for advanced fibrosis, then I think that this patient is going to have simple steatosis, and I'll stop my evaluation or assessment of disease severity there. However, if these clinical prediction scores show intermediate or high risk for advanced fibrosis, then often I'll graduate to another imaging-based test something called Vibration-Controlled Transient Elastography, or something that's commercially known as FibroScan. And again, this will help triage my patient in terms of how much scar tissue is in the liver. And the reason that we emphasize scar tissue in the liver, or fibrosis, is this is the metric that's associated with both all-cause and liver-related mortality. Depending on what result I get from this test, I can better label the patient as having cirrhosis of the liver or perhaps lesser degrees of fibrosis.

Dr. Buch:
That's great, but here's an additional question. Between NFS and FIB-4, do you find any difference in accuracy of prediction of fibrosis?

Dr. Barritt:
They're both reasonable. If you look at sensitivity, specificity, and the area under the receiver operating curves for predicting advanced fibrosis, they both score at about a 0.8, which means they're not perfect, but because they're free, they're reasonable for routine clinical use. So while the proprietary test may be slightly better when you're applying these tests to essentially a third of the population, the ones that are free I believe are often going to be the ones that are best at a population level, and that, perhaps, slight iterative benefit of using some of the other serum-based tests may not be worth it in the end of the day.

Dr. Buch:
And continuing with that thought, are there any concerns with regard to false-negatives on NFS score or FIB-4 score?

Dr. Barritt:
Yeah, there's always a concern on both ends, false-negative and false-positive. So say you get a falsely low score that you think that the patient does not have advanced fibrosis and the patient actually does. This reminds me of advice that one of my attendings gave me in residency. "We don't marry our diagnoses. We just date them." And what she meant by that is it's okay for us to change our mind. And NAFLD is not a one-and-done interaction with the physician. This is a long-term chronic process, where we will see the patients longitudinally, and we can make these reassessments longitudinally as well too. And so whenever we get conflicting information, often we can employ series of tests or combine tests for greater accuracy.

But I think the major point is we are seeing these patients on an every, say, 6-to-12-month basis, so I'm not too concerned that their

disease will advance and get out of hand if we make the wrong call initially.

Dr. Buch:
Well that brings us to the end of the first part of our two-episode series focusing on non-alcoholic fatty liver disease. I'd like to thank my guest, Dr. Sidney Barritt, for joining me today. Dr. Barritt, it was great speaking with you!

Dr. Barritt:
Well, thank you very much for having me. I enjoy talking about this topic a lot, so thanks again.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To revisit this discussion and to find part two, visit ReachMD.com/GI Insights, where you can Be Part of the Knowledge. Thanks for listening!