Autoimmune Hepatitis

Diagnosis, overlap syndromes, drug-induced AIH-like injury, pretreatment workup, first-line therapy, pregnancy, acute severe AIH/ALF, withdrawal, nonresponse, and post-transplant recurrence.

2019 AASLD Practice Guidance & Guidelines
Diagnosis and Management of Autoimmune Hepatitis in Adults and Children
Mack, Adams, Assis et al. · Hepatology 2020;72:671

FORMAT *43 statements — mostly expert-consensus guidance (GS); GS24–25 are formal GRADE recommendations. Grouped by clinical theme.*

1 Diagnosis & Associated Conditions

GS	STATEMENT
1	Diagnosis requires compatible histology, supported by elevated aminotransferases, elevated IgG and/or positive autoantibodies, and exclusion of viral hepatitis
2	Initial serology: ANA + SMA in adults; ANA, SMA, and anti-LKM1 in children — add further autoantibody tests if diagnosis remains unclear
3	Diagnostically challenging cases should be reviewed by/referred to an experienced liver center before starting therapy
4	Consider AIH in all acute/chronic liver disease, including asymptomatic LFT abnormalities, ALF, and autoantibody-negative hepatitis
5	Screen for celiac and thyroid disease at diagnosis
6	Assess for RA, IBD, autoimmune hemolytic anemia, diabetes, and other extrahepatic autoimmune disease per symptoms/provider concern
7	AIH + cholestatic labs/histology + positive AMA → consider AIH–PBC overlap syndrome
8	AIH + cholestatic labs + bile duct injury/loss + chronic UC → evaluate for large-duct PSC by cholangiography (AIH–PSC overlap)
9	Paris criteria can aid AIH–PBC overlap diagnosis but may exclude a substantial minority of true overlap cases

2 Drug-Induced AIH-Like Injury

GS	STATEMENT
10	Always consider drug-induced AIH-like injury in the differential diagnosis
11	Withdraw offending agent and monitor for laboratory resolution
12	Start glucocorticoids if severe (e.g., meets Hy's law) or labs fail to improve/worsen after drug withdrawal
13	Laboratory flare after glucocorticoid withdrawal suggests underlying true AIH requiring immunosuppression

3 Pretreatment Workup & Monitoring

GS	STATEMENT
14	Serum fibrosis biomarker panels are unvalidated in AIH — do not use
15	VCTE can detect advanced fibrosis/cirrhosis but defer ≥6 months after successful treatment to avoid inflammation-related confounding
16	Consider screening for absent/near-absent TPMT activity before starting AZA
17	HBsAg-negative/anti-HBc-positive at diagnosis → periodic HBsAg/HBV DNA testing during conventional prednisone-based therapy
18	Prior HBV infection + high-dose glucocorticoids or B-cell-depleting agents → moderate reactivation risk — monitor/consider prophylaxis
19	Vaccinate all susceptible AIH patients per age-specific CDC/ACIP schedules

4 Safety & Supportive Monitoring

GS	STATEMENT
20	Baseline BMD in adults with osteoporosis risk factors; repeat every 2–3 years of continuous glucocorticoid therapy
21	Check 25-hydroxyvitamin D at diagnosis and annually thereafter
22	Proactively identify and address barriers to long-term medication adherence
23	Monitor for depression and quality-of-life changes throughout management, ideally with validated questionnaires

5 First-Line Treatment (GRADE Recommendations)

GS	STATEMENT
24	No cirrhosis/acute severe AIH: budesonide + AZA OR prednisone/prednisolone + AZA as first-line treatment
25	Cirrhosis or acute severe AIH: do NOT use budesonide (conditional recommendation, very low certainty)

6 Pregnancy & Family Planning

GS	STATEMENT
26	Aim for 1 year of biochemical remission before conception
27	Counsel women of reproductive potential on risks of active AIH in pregnancy and flare risk during/after pregnancy
28	Continue maintenance glucocorticoid and/or AZA doses throughout pregnancy
29	MMF is contraindicated in pregnancy — counsel before starting in women of reproductive potential
30	Cirrhotic women pregnant or planning pregnancy within 1 year: screen for varices pre-conception or in 2nd trimester; treat with banding/beta-blockers as needed
31	Monitor closely for flare during the first 6 months postpartum

7 Acute Severe AIH & ALF

GS	STATEMENT
32	Acute severe AIH: treatment trial with prednisone/prednisolone alone; AIH + ALF: evaluate directly for LT
33	No improvement or clinical worsening within 1–2 weeks of glucocorticoids → evaluate for LT

8 Treatment Withdrawal & Relapse

GS	STATEMENT
34	Drug withdrawal/treatment-free remission possible in a minority — consider if aminotransferases and IgG normalized for a sustained period
35	Pre-withdrawal liver biopsy is valuable (excludes occult inflammation, reduces relapse) but not mandatory in adults
36	Monitor closely for relapse — regular labs for first 12 months post-withdrawal, then annually for life
37	Relapse → promptly reinstitute original treatment until remission, then transition to long-term maintenance

9 Nonresponse — Second/Third-Line Therapy

GS	STATEMENT
38	Nonresponse to first-line treatment → reevaluate original diagnosis accuracy and medication adherence
39	Anti-TNF and anti-CD20 are possible alternatives after first- and second-line failure, but supporting data are limited
40	Consider adding UDCA to prednisone/prednisolone + AZA in AIH overlap syndromes

10 Long-Term Surveillance & Post-Transplant Recurrence

GS	STATEMENT
41	HCC surveillance in cirrhotic AIH: hepatic ultrasound ± AFP every 6 months
42	Suspect recurrent/de novo AIH or plasma cell hepatitis-rejection in LT recipients with allograft injury labs; obtain biopsy, IgG, and autoantibodies to distinguish from other causes
43	Add predniso(lo)ne + AZA to the calcineurin inhibitor to achieve remission in recurrent/de novo AIH

Mack CL, Adams D, Assis DN, et al. AASLD Practice Guidance and Guidelines: Diagnosis and Management of Autoimmune Hepatitis. *Hepatology.* 2020;72(2):671–722.