Alcohol-Associated Liver Diseases

Screening/brief intervention, AUD treatment, patient education, alcoholic hepatitis diagnosis/prognosis, severe AH treatment, and liver transplantation.

2019 AASLD Practice Guidance
Diagnosis and Treatment of Alcohol-Associated Liver Diseases
Crabb, Im, Szabo et al. · Hepatology 2020;71:306

FORMAT *22 numbered guidance statements — narrative consensus format (not GRADE-rated); grouped by clinical theme.*

1 Screening & Brief Intervention

GS	STATEMENT
1	Routinely screen all patients (primary care, GI/hepatology clinics, ED, inpatient) for alcohol use with validated questionnaires
2	Offer brief intervention, pharmacotherapy, and referral to treatment for hazardous drinking (AUDIT-C ≥4, AUDIT >8, binge drinkers)
3	Alcohol biomarkers (urine/hair ethyl glucuronide, urine ethyl sulfate, PEth) aid diagnosis and support recovery — unaffected by liver disease, so preferred

2 AUD Treatment & Referral

GS	STATEMENT
4	Refer patients with advanced ALD and/or AUD to AUD treatment professionals for full access to treatment options
5	Multidisciplinary, integrated ALD + AUD management improves alcohol abstinence rates
6	Acamprosate or baclofen can be considered for AUD in ALD, based on limited data

3 Patient Education on Alcohol Use

GS	STATEMENT
7	No liver disease: educate on safe limits — men ≤2 standard drinks/24h, women ≤1 standard drink/24h
8	ALD or other liver disease (NAFLD, NASH, viral hepatitis, hemochromatosis): counsel that no level of drinking is safe — advise abstinence

4 Diagnosis of Alcoholic Hepatitis

GS	STATEMENT
9	Diagnose AH (definite, probable, possible) using published consensus criteria

5 Prognostic Assessment in AH

GS	STATEMENT
10	Use lab-based prognostic scores to determine prognosis in AH
11	Maddrey Discriminant Function (MDF) ≥32 → assess need for corticosteroids or other medical therapy
12	MELD >20 should also prompt consideration of steroid treatment
13	Promote abstinence from alcohol to improve long-term AH prognosis

6 Treatment of Severe AH

GS	STATEMENT
14	Oral prednisolone 40 mg/day to improve 28-day mortality in severe AH (MDF ≥32) without corticosteroid contraindications
15	Adding IV N-acetylcysteine to prednisolone may improve 30-day survival in severe AH
16	Use the Lille score after 7 days of corticosteroids to reassess prognosis, identify nonresponders, and guide treatment course
17	Address and treat malnutrition in AH, preferably with enteral nutrition
18	Abstinence is key to long-term survival — apply AUD treatment methods to increase abstinence
19	Pentoxifylline is no longer recommended for treatment of AH

7 Liver Transplantation

GS	STATEMENT
20	Decompensated alcohol-associated cirrhosis with CTP class C or MELD-Na ≥21 → refer and consider for liver transplantation
21	Candidate selection for LT in alcohol-associated cirrhosis should NOT be based solely on a fixed sobriety interval
22	LT may be considered in carefully selected patients with favorable psychosocial profiles and severe AH not responding to medical therapy

Crabb DW, Im GY, Szabo G, Mellinger JL, Lucey MR. AASLD Practice Guidance: Diagnosis and Treatment of Alcohol-Associated Liver Diseases. *Hepatology.* 2020;71(1):306-333.