Nonalcoholic Fatty Liver Disease

Cardiometabolic risk management, alcohol/cofactor screening, risk stratification, noninvasive testing, lifestyle/bariatric therapy, and pharmacotherapy for NAFLD/NASH.

2023 AASLD Practice Guidance
Clinical Assessment and Management
of Nonalcoholic Fatty Liver Disease
Rinella et al. · Hepatology 2023;77:1797–1835

FORMAT *29 numbered guidance statements — narrative consensus format (not GRADE-rated); grouped by clinical theme.*

1 Cardiometabolic Risk Factor Management

GS	STATEMENT
1	Statins are safe and recommended for CVD risk reduction across the NAFLD spectrum, including compensated cirrhosis
2	Limited data on statins in decompensated cirrhosis — may consider with careful monitoring if high CVD risk
3	Manage hypertriglyceridemia via lifestyle change + omega-3 fatty acids, icosapent ethyl, or fibrates
4	Diabetes → higher risk of NASH/advanced fibrosis — screen for advanced fibrosis
5	Screen NAFLD patients for T2DM

2 Alcohol & Other Modifiable Cofactors

GS	STATEMENT
6	Alcohol is a cofactor for disease progression — assess intake regularly
7	Clinically significant fibrosis (≥F2): complete alcohol abstinence
8	NAFLD more common with androgen deficiency, but routine testosterone testing not supported; treat hypogonadism if clinically evident

3 Risk Stratification & Screening

GS	STATEMENT
9	General population-based NAFLD screening not advised
10	Hepatic steatosis or clinically suspected NAFLD (obesity/metabolic risk factors): primary risk assessment with FIB-4
11	High-risk (T2DM, medically complicated obesity, family history of cirrhosis, >mild alcohol use): screen for advanced fibrosis
12	Pre-DM/T2DM or ≥2 metabolic risk factors: repeat FIB-4 every 1–2 years
13	NASH cirrhosis = highest risk — routine HCC/variceal surveillance and decompensation monitoring
14	Suspected advanced NASH or discordant NITs → refer to specialist
15	Aminotransferases often normal in advanced NASH — do not use alone to exclude clinically significant fibrosis
16	First-degree relatives of NASH-cirrhosis patients: counsel on increased risk and offer fibrosis screening

4 Noninvasive Testing

GS	STATEMENT
17	Standard ultrasound not recommended to identify steatosis (low sensitivity)
18	CAP (point-of-care) may identify steatosis; MRI-PDFF can additionally quantify it
19	FIB-4 ≥1.3: use VCTE, MRE, or ELF to exclude advanced fibrosis

5 Lifestyle & Bariatric Surgery

GS	STATEMENT
20	Overweight/obese: prescribe caloric-deficit diet; favor limited carbs/saturated fat, high fiber/unsaturated fats (e.g., Mediterranean diet)
21	Encourage increased activity; individualized exercise prescription may aid sustainability beyond weight loss alone
22	Consider bariatric surgery if criteria met — resolves NAFLD/NASH in the majority of patients

6 Pharmacotherapy

GS	STATEMENT
23	No FDA-approved NAFLD medications currently; comorbidity-approved drugs with potential NAFLD benefit may be considered
24	Semaglutide (approved T2DM/obesity indications) in NASH: cardiovascular benefit + improves NASH
25	Pioglitazone improves NASH — consider in patients with T2DM
26	Vitamin E may be considered in select non-diabetic patients — improves NASH in some
27	Semaglutide/pioglitazone/vitamin E: no demonstrated antifibrotic benefit; not well studied in cirrhosis
28	Metformin, UDCA, DPP-4 inhibitors, statins, and silymarin lack meaningful histological benefit — do not use to treat NASH itself

7 Monitoring Treatment Response

GS	STATEMENT
29	ALT improvement or reduction in liver fat on imaging can serve as a surrogate for histological improvement in disease activity

Rinella ME, Neuschwander-Tetri BA, Siddiqui MS, et al. AASLD 2023 Practice Guidance on Nonalcoholic Fatty Liver Disease. *Hepatology*. 2023;77(5):1797–1835.