Alcoholic Hepatitis and Preventing Patients from Reaching the Pint of No Return

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Introduction

- Alcoholic hepatitis (AH) results from long-term alcohol abuse that leads to:
  - Liver inflammation + impaired hepatic function
- Typical patient:
  - Between 40 – 60 years old
  - H/o heavy drinking (>100g) for years[1]
- Clinical and lab features:
  - Jaundice, anorexia, fever, abdominal pain
  - Moderate elevation of AST and ALT
  - AST/ALT ratio ≥ 2
  - Increased bilirubin, white count, INR[2]
- Overall a **clinical diagnosis!**

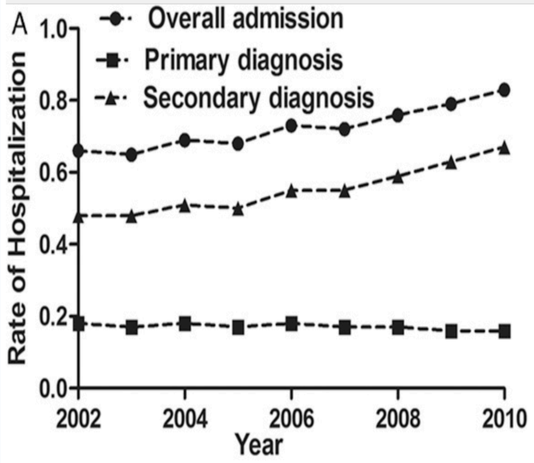
Case Description

- A 56 yo man with PMH homelessness, hep C (s/p treatment and SVR), EtOH use disorder presented with subacute-on-chronic nausea, vomiting, abdominal pain, dark stools, fatigue
  - 10 beers/day for 15 years prior to admit
  - **Vitals**: HR 110 and BP 105/75, afebrile, O2 98% on room air
  - **Exam:** jaundiced, tremulous, moderate TTP in RUQ
  - **Labs:**
    - Hgb 6.6
    - WBC 12.7
    - AST 230
    - ALT 61
    - T bili 8.1
    - INR 1.3
    - EtOH level 156
  - **Imaging:**
    - CT chest-abdomen-pelvis with hepatic steatosis

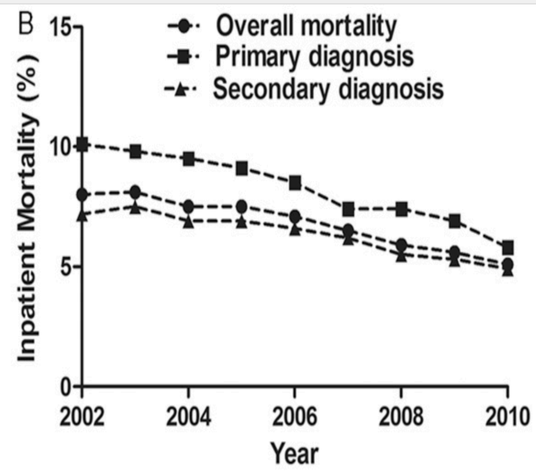
Hospital Course

- IV PPI, CIWA protocol
- IVF prn and 1 unit pRBC
  - Hemodynamically stable throughout
- Endoscopy could NOT explain anemia
  - EGD: 2mm erosion in gastric cardia, AVM in duodenum
  - Colonoscopy: 1 small polyp
- Diagnosed with **alcoholic hepatitis**
- Labs improved with supportive therapy
  - Hemoglobin: 6.6 > 7.7 > 8.0 > 8.8
  - AST: 230 > 190 > 160 > 120
  - ALT: 61 > 55 > 50 > 35
  - T bili: 8.1 > 8.8 > 8.2 > 6.5 > 5.3
- Discharged with **outpatient substance abuse counseling**
- Presented 4 weeks later in s/o continued EtOH use

Trends in Alcoholic Hepatitis



- **Rate of hospitalization** for AH in the United States from 2002 – 2010

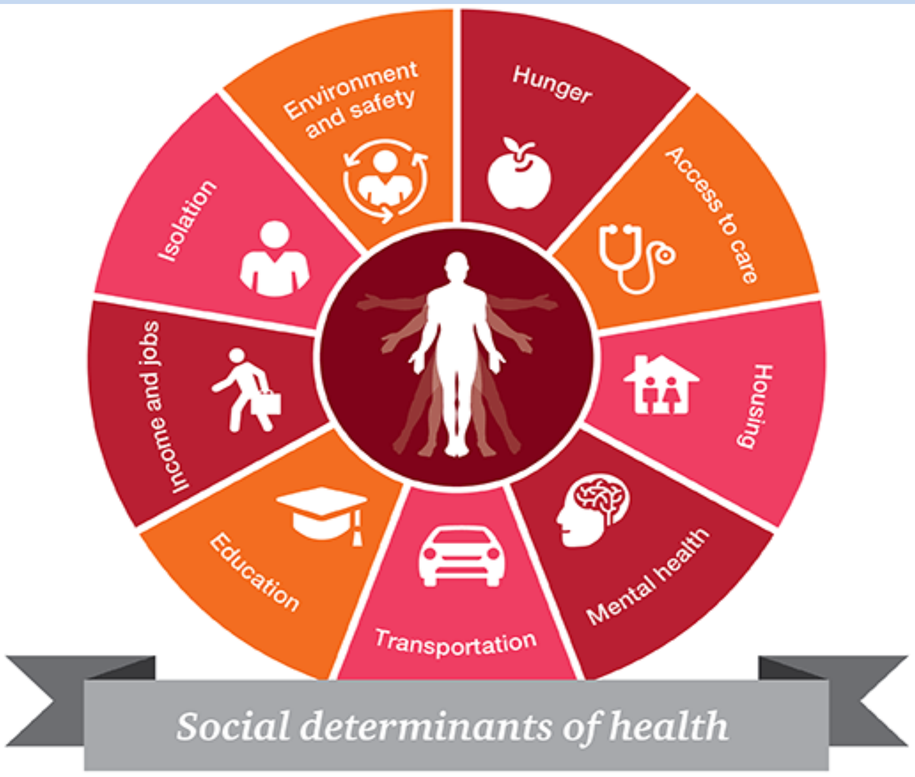


- **Inpatient mortality** for AH from 2002 – 2010

Psychosocial Treatment Options

Motivational Interviewing	Mutual Help Groups
Brief Intervention	Contingency Management
Cognitive-Behavioral Therapy	Residential Treatment

What makes up our health?



Discussion

- Most of recent AH literature:
  - Focuses on mortality benefit of steroids
  - Alternative treatments options (such as pentoxifylline)
- Scoring systems have been developed to assess disease severity
  - Maddrey Score
  - Lille Score
- If patient has mild/moderate AH (Maddrey <32) → steroids NOT recommended
  - Supportive therapy alone
- If severe AH (Maddrey ≥ 32) → steroids!
  - Lille score after 1 week for +/- steroids[3]

- **But this misses larger issue of EtOH in AH!**
- **Abstinence from EtOH → only independent predictor of long-term survival in AH**
  - One study shows 5-year survival of 75% in abstainers vs 26% in relapsed drinkers[4]
- Highest mortality benefit gained is through resources to maintain sobriety
  - Patients needs more than just outpatient counseling
- **Integrated psychotherapy is effective for achieving abstinence**
  - A systematic review found that 45% of patients in a psychosocial intervention group achieved abstinence vs 36% in the control group
  - One study with 74% vs 45% abstinence[5]

Teaching Points

- Alcoholic hepatitis (AH) results from long-term, heavy alcohol abuse
- Jaundice, anorexia, fever, abdominal pain, mild transaminitis and AST/ALT ratio ≥ 2
- Treat with steroids if Maddrey score ≥ 32
- **Getting AH patients to stop drinking is the most beneficial treatment for their health**
  - **A deliberate effort utilizing integrated, multidisciplinary care can achieve this!**

References

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5) Khan, et al. Efficacy of psychosocial interventions in inducing and maintaining alcohol abstinence in patients with CLD. *Clin Gastroenterol Hepatol.* 2016:14(2):191-202.
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