TSANZ Guidelines updated November 2022

6.2.4 Early transplantation for severe acute alcoholic hepatitis

Alcoholic hepatitis (AH) is a clinical entity that is usually, but not always, diagnosed by biopsy. Severe AH that fails to respond to medical therapy has a mortality of 70% at two months. Liver transplantation is the only lifesaving treatment for these patients. International data suggests that the three-year survival of carefully selected patients transplanted for a first episode of alcoholic hepatitis is equivalent to that of patients transplanted for other indications. The survival and comparatively low alcohol relapse rates suggest the feasibility of performing liver transplantation in this group of patients in Australia in those units that have the necessary resources for patient assessment and post-transplant alcohol related follow up. In those units that have an active AH policy the following are required.

Inclusion criteria:

1. Patients must meet the specific definition of severe AH33:
    a. Onset of jaundice within prior 8 weeks
    b. Ongoing consumption of at least >40g for women and >60g for men of alcohol/day for six months or more, with less than 60 days of abstinence before onset of jaundice
    c. AST and ALT > 50 IU/L but <400 IU/L
    e. Liver biopsy confirmation (strongly recommended, need transjugular)
    f. Maddrey Score of >32 AND MELD score >20.
2. Patient must be a non-responder to appropriate medical therapy. For most patients this will be corticosteroids managed as per Lille criteria, though some patients will have a contraindication to steroids.
3. Presentation of severe AH must be the first liver decompensating event
4. Favourable psychosocial profile as determined by multidisciplinary team
5. Consensus agreement by the unit's transplant committee

Exclusion criteria

1. Prior documented diagnosis of advanced alcohol related liver disease such as cirrhosis or previous decompensating liver event (e.g. jaundice, ascites, variceal bleed)
2. Presence of severe alcohol use disorder as classified by DSM V (previously termed alcohol dependence)
3. Absence of insight into alcohol as cause of liver disease / current presentation
4. Absence of agreement by patient to adhere to lifelong total alcohol abstinence and participate in long term post-transplant relapse and monitoring

At the outset, patients should be diagnosed with dual pathology of both alcohol use disorder and liver disease. For optimal outcomes, both conditions should be managed in the long term with equal attention. Alcohol relapse prevention should be integrated into post-transplant management in a structured way, preferably with regular alcohol biomarker monitoring. Relapse prevention should be multidisciplinary, and evidence based, performed by an experienced practitioner skilled in a variety of psychotherapeutic techniques. Consideration should be given to pharmacotherapy for patients with ongoing cravings. There should be rapid identification and simple pathways to escalate support for those patients identified as having "slipped" to prevent the return to the pattern of sustained drinking.