Close to 65% of adult primary liver transplants conducted in Australia and New Zealand are for potentially preventable diseases, report Melbourne researchers.

And doctors can significantly reduce the burden by implementing effective primary and secondary prevention strategies, they report in an evaluation of the relative contribution of potentially preventable liver diseases to liver transplant numbers. They include hepatitis C, hepatitis B, alcohol-related liver disease and non-alcohol-related fatty liver disease among preventable diseases.

Overall, 1252 of 3266 adult primary liver transplants (38.3%) were performed for potentially preventable liver disease over the 1985 to 2012 study period. But the proportion soared from 21.2% at the beginning of the period to 63.5%.

Only half of adults on the liver transplant waitlist were transplanted, with a 10% attrition rate due to disease progression or death.

The researchers say needle and syringe exchange programs and opioid substitution therapy are effective methods to counteract hepatitis C spread but are under-used among those at risk.

They call for better sex education programs for HIV-positive men who have sex with men as they are more likely to contract hepatitis C that progresses rapidly.

The researchers also stress the importance of screening at-risk individuals and treating those infected with direct-acting antivirals to reduce viral transmission.

They note the suboptimal uptake of strategies to counter alcohol abuse such as support groups and providing anti-craving medications like baclofen.

“Alcohol-related liver disease has been shown to regress with abstinence, thus support and treatment strategies for those already affected by ALD can lead to improvements in liver function and avoid the need for transplantation,” the researchers write in the Journal of Gastroenterology and Hepatology.

They say non-alcoholic fatty liver disease has become a “burgeoning epidemic” and due to a lack of recognition.

“Addressing the metabolic syndrome and obesity through diet modification and exercise remains the mainstay for both primary prevention of NAFLD and second prevention of advanced liver disease and NAFLD associated HCC,” they write.

They have called for a stronger commitment among doctors to improve patient access to screening and treatment.

The increasing burden of potentially preventable liver disease among adult liver transplant recipients: a comparative analysis of liver transplant indication by era in Australia and New Zealand

What do you think?
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References:
FODMAP pioneer hits back at criticism

STAFF WRITER

The Australian who pioneered the FODMAP diet for irritable bowel syndrome has hit back at a review in a British journal which argues there is “very limited evidence for its use”.

Professor Peter Gibson (pictured), of Monash University, has outlined six main points of rebuttal. These are:

1. The perspective is skewed

The article is trying only to put the data reviewed into the perspective of evidence using concepts developed for pharmaceuticals. It has not been delivered with the perspective that there are no dietary therapies with pharmaceutical-grade evidence, and there are no drugs that have more than a minor benefit in a minority of patients with IBS.

2. It overrates usual dietary advice

The authors start the article talking about usual dietary advice. There is no high-quality evidence for this strategy. In fact, there is little in the way of evidence at all for the current recommendations, except “expert opinion”.

3. It downplays good evidence

The major criticism is that there is no long term RCT evidence of efficacy. That will never occur as it is impossible to do (diet is not a drug). There are long-term data on efficacy in prospective observational studies, which the authors apparently do not feel warrant discussion.

It is incorrect to say that there is no high-quality evidence for efficacy – just that there is no high-quality evidence for use and safety in the long term.

4. A difference of opinion

We differ from the opinion expressed in their value judgment not on the issues raised. The value judgment they apply is fit for drugs but not for dietary therapy, as most of the criticisms cannot methodologically be addressed.

With gluten-free diet has no placebo-controlled randomised long-term studies of efficacy. Does that mean it should be used only as a second line to other strategies with little evidence at all? The use of gluten-free diet is largely based upon understanding of mechanisms for coeliac disease and longer term observational studies.

5. The diet isn’t too hard

Too difficult is an interesting criticism that comes up often. However, if, as in the Danish study, eight of many patients found the diet too difficult, then this is better than the compliance rate of adherence to drugs intake in drug trials. It is not a criticism. Most who criticise the diet as too difficult have little experience of the diet and do not actually understand the implementation of the diet. It is always stated that it should be done with dietitian-directed input/education. It is not a therapy for all IBS and does require patient input and involvement – like taking of medications.

6. It’s anonymous

This article is anonymous (apparently). There may be the authorship somewhere but I could not see it. It is always nice to know who is making the recommendations.

Does a low FODMAP diet help IBS? What do you think?

Click here to comment

References:

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THE LONG-AWAITED RESPONSE* IN THE TREATMENT OF HEPATITIS C PATIENTS

Bristol-Myers Squibb is proud to be a part of this transformational time in the treatment of hepatitis C. To find out more about our new treatments please contact Medical Information on 1800 067 567 or email: medinfo.australia@bms.com

*According to EASL guidelines, long-term follow-up studies have shown that a sustained virological response (SVR) – defined as undetectable HCV RNA 12 (SVR_12) or 24 (SVR_24) weeks post-treatment end – corresponds to a definitive cure in more than 99% of cases of hepatitis C.
Childhood abuse linked to ulcerative colitis

HUGO WILCKEN

A Canadian study has found the risk of ulcerative colitis is much greater in people who suffered physical or sexual abuse as a child. Data from a population-based sample of 22,000 people from a mental health survey shows the odds of ulcerative colitis were 2.28 times higher in those who reported that an adult had at least once kicked, bit, choked, burned or physically attacked them as a child.

The risk was even greater for those who reported being forced into sexual activity as a child, which conferred a 2.64 greater likelihood of ulcerative colitis.

The associations remained strong even after a range of factors were accounted for, including socioeconomic status, mental health and health behaviours.

But surprisingly, the researchers from the University of Toronto found no association between childhood abuse and Crohn’s disease, despite its similarities with ulcerative colitis. They also found no association with witnessing parental domestic violence and either of the two inflammatory diseases.

The researchers say the biological mechanisms underlying the associations are not clear. They also caution that as the study was cross-sectional, it cannot determine a cause-and-effect relationship.

“Future research that can address the epigenetic and neuroendocrine factors should investigate pathways through which early adversities may translate into one type of IBD and not another,” they write in the journal Inflammatory Bowel Diseases.

Childhood maltreatment is associated with ulcerative colitis but not Crohn’s disease: findings from a population-based study

What do you think?
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THE LONG-AWAITED RESPONSE* IN THE TREATMENT OF HEPATITIS C PATIENTS1–3

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