Early Transplantation for Alcohol-Related Cirrhosis: Risks, Resources, and Relapse

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Letter to editor

Dear editor,

Early transplantation in alcohol-related liver diseases is controversial, and fraught with medical, societal and humanitarian challenges. The work by Carrique et al. is thus unique, and represents the highest level of commitment to patient care as well as clinical research [1]. This data provides interesting insights into challenging the ‘6-month-rule’, and establishing a possible new standard of care for patients with alcohol use disorder.

This vast dataset involved 703 patients evaluated by an intense multidisciplinary screening process, after which 164 patients underwent medical evaluation and ultimately 44 were transplanted [1]. This signifies a very carefully curated cohort of patients with possibly the least risk of relapse. Yet, nearly 10% patients who underwent medical evaluation, and 7% of those transplanted resumed alcohol use within a relatively short period (median follow up - 339 days). In other studies with longer follow up, the return to alcohol ranges from 23% to 34% [2]. Long term abstinence data is crucial to look at implications of this program. While survival among abstinent versus early alcohol use may not differ much at 1 year, the numbers are very different at the end of 5 years (95% v/s 53%) [3].

While the 6-month rule may indeed be arbitrary, it is currently the standard of care. To change this requires evidence to favour a change. In cadaveric programs, a graft organ is a societal resource, and a severely limited one at that. A transplant expedited is another transplant delayed. Before this model may be implemented in other centers, it would be prudent to check if there were any changes in the waitlist morbidity and mortality when this policy was instituted. Additionally, long term compliance and survival needs to be assessed. Only then should this protocol be recommended outside of trials.
It is also important to note that even in the current protocol of expedited transplantation, patients had a mean abstinence period of 4.7 month at the time of medical evaluation [1]. This, added to the 69 days mean time on waitlist adds up to an abstinence close to 6 months for a significant proportion of patients. So, before generalizing this protocol, we need more numbers and longer follow-up of these patients.

Conversely, the results of this study do open an avenue for living donor transplantation for alcohol related liver disease. With living related donor being a person-specific resource, the ethical implications of organ allocation change [4]. In such setups, carefully selected patients who undergo proper screening and regular follow-ups may potentially be transplanted without a waiting period. However, we feel this too needs more data before it may be implemented in clinical practice.

References:


