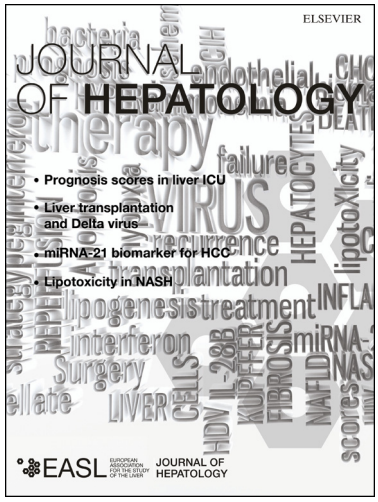

Letter to the Editor

Liver Transplantation and Severe Acute Alcoholic Hepatitis: an Ethical Consideration

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Liver Transplantation and Severe Acute Alcoholic Hepatitis: an Ethical Consideration

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To the Editor:

We have read the excellent paper by Donckier et al. (1).

Authors conclude that there are no major ethical barriers in transplanting patients affected by severe alcoholic hepatitis (SAH), non-responder to medical therapy.

We totally agree with this statement (2).

Some recent clinical experiences have shown how to achieve favourable outcomes post transplantation in patients affected by AAH, non-responder to medical therapies (3).

Most Western societies proudly promote alcohol consumption through increasingly sophisticated advertising campaigns, but paradoxically patients with SAH are denied access to liver transplantation (LT).

Moreover, it's internationally well-known that so-called "moderate" amounts of alcohol, particularly if associated with other risk factors, may lead to cirrhosis, and to the need for a LT (4, 5).

Social drinkers are usually considered as classy, cultured, and responsible people, whereas alcohol-addicted persons are commonly labelled as depraved and are marginalized by society.

Liver transplant in patients with SAH is not accepted in the absence of a 6-month period of abstinence from alcohol.

An interesting question arises from this problem: is it acceptable to allocate scarce resources to patients who do not meet classical admissions criteria ?

To date, nobody has been able to establish a certain period of abstinence, which ensures no future alcohol relapses; apart from this fact, in case of SAH, the 3-month mortality rate is about 70%.

Can we assume the right to refuse a treatment option for a patient? Is similar behaviour, in light of new clinical evidence, ethically correct?

Our primary purpose should be the care of our patient's life. We should, then, do our best to modify and adapt our attitude towards alcohol-addicted patients.

Obviously, some patients' features, such as the presence of severe psychiatric comorbidities, or the absence of an adequate social support, should be taken into account. Nevertheless, in our opinion, there are two main variables that may guarantee the maintenance of alcohol abstinence after a liver transplant. The first one is the attendance at self-help groups. The second variable is the close cooperation with an

Alcohology Unit (AU), and with expert Hepatologists who are able to deal with both the hepatological disease and the alcohol addiction problem (6).

Recently Addolorato et al. (7) have demonstrated that the presence of an Alcohol Addiction Unit within a liver transplant centre may significantly reduce the risk of alcohol relapse and the recurrence of disease after LT, and may allow liver transplantations in some selected patients, even in case of less than 6 months of abstention.

In our clinical experience (published data) (2, 8) seven patients, non-responder to therapies, with clinical evidence of SAH (Maddrey Discriminant Function > 32) and hepato-renal syndrome, were submitted to transjugular intrahepatic portosystemic stent shunt (TIPS), and then submitted to transplant. Steroid therapy was contraindicated because of the presence of renal failure. All patients were followed-up by the Alcohology Unit, and attended self-help groups. None of them have relapsed over the next 5 years.

It is necessary to turn the ethical tide toward a self-inflicted injury such as alcoholic liver disease (ALD). What are we, professional physicians, able to offer our patients beyond a routine palliative care to minimize the risk of relapses, and, subsequently, of graft deterioration?

We believe that selected patients, affected with SAH, and non-responding to therapies, should have the opportunity to undergo a liver transplant if supported by expert Hepato-alcohologists, and self-help groups (Alcoholic Anonymous, Clubs of Alcoholics in Treatment) and other associations.

In the post-LT phase, the patient should be surrounded by a protective network where medical social workers, and families cooperate closely with self-help associations; all of which significantly increases the chance of reducing relapses.

The relevant scientific community has the duty to promote scientific and cultural initiatives to inform the population, and to define guidelines that should be characterized by innovative healthcare activities in an area, such as those related to ethics, alcohol and transplantation, where too many uncertainties still do exist.

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