Acute Alcoholic Hepatitis: Therapy

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KEYWORDS

• Corticosteroids • Prednisolone • Pentoxifylline • Nutrition • Anti-TNFα
• Antioxidants • Liver transplantation • Palliative care

KEY POINTS

- Alcoholic hepatitis (AH) carries significant morbidity and mortality.
- Every patient with AH should be advised to stop all alcohol consumption and should be provided with sufficient nutrition.
- Those patients who meet the criteria for severe AH should be considered for therapy with prednisolone, and all patients with severe AH who fail medical therapy should be considered for liver transplantation (LT).
- All patients with severe AH who fail medical therapy and are considered unsuitable for LT should be referred for palliative care consultation.

INTRODUCTION

Alcoholic hepatitis (AH) is a term used to describe both a clinical syndrome and a set of histopathologic findings. AH occurs in the setting of alcohol use disorder (in common parlance, *alcoholism*). All treatment of AH begins with the premise that patients need to establish and maintain abstinence from alcohol. Assessment of the psychological state is an important element in the holistic care of an individual patient with severe AH, but this is beyond the scope of the article. Similarly, because many patients with AH have been drinking up to the moment of admission to the hospital, care of patients at risk for alcohol withdrawal syndrome is key to the recovery process. Management of alcohol withdrawal syndrome has been thoroughly reviewed elsewhere and is not covered here.[1] Finally, it is worth stating that severe AH usually arises in patients with established cirrhosis, although patients are often unaware of this fact. Consequently, as mentioned in the *Patient evaluation overview* section, typical patients with AH are at risk for the other end-organ failures seen in sick cirrhotic patients.

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Box 1
Five controversies regarding the evaluation and treatment of alcoholic hepatitis

1. How to distinguish acute-on-chronic liver failure from AH
2. Need for liver biopsy to diagnose AH
3. Use of corticosteroids to treat severe AH
4. Role (if any) of liver transplantation to treat patients with ALD with short duration of sobriety
5. Role of palliative care in the management of patients with AH

Moreover, management of ascites; fluid and electrolyte imbalances; cardiovascular, respiratory, and renal function; and hepatic encephalopathy are alluded to only tangentially. The focus of this article is the current state of management of the AH syndrome itself. In particular, the authors address 5 controversies related to the evaluation and treatment of patients with AH as shown in **Box 1**.

PATIENT EVALUATION OVERVIEW

Evaluation of patients with a putative diagnosis of AH begins with a careful history, including questions about the most recent use of alcohol. The National Institute on Alcohol Abuse and Alcoholism's quantity and frequency questions are useful to gauge the amount of alcohol that patients have been consuming (**Box 2**). Taking a history of exposure to other drugs of addiction is essential. Next, it is wise to corroborate the addiction history with a close family member or friend.

For more information on diagnosis of alcoholic liver disease, please see Ryan E. Childers and Joseph Ahn: Diagnosis of Alcoholic Liver Disease: Key Foundations and New Developments, in this issue. We wish to draw attention to the importance of distinguishing between AH and 'acute on chronic liver failure' (ACLF). As mentioned earlier, most patients with severe AH have already progressed to cirrhosis of the liver, even though many are unaware of this fact. Therefore, many are vulnerable to infection (**Box 3**). AH is a form of systemic inflammatory response syndrome (SIRS) that shares many features with systemic infection (**Box 4**). Common causes of infection in patients with ALD include pneumonia, spontaneous bacterial peritonitis in patients with ascites, urinary tract infection, cellulitis, and *Clostridium difficile* enterocolitis.[2] Hospitalized patients are prone to intravenous (IV) catheter–associated or urinary catheter–associated infections. Failure to recognize infection and/or difficulty distinguishing between AH and SIRS-like conditions that mimic AH confound day-to-day clinical practice and potentially contaminate the study populations in clinical trials. Chronic exposure to proton pump inhibitors and antibiotics also increase the infection risk in cirrhotic patients.

Box 2
National Institute on Alcohol Abuse and Alcoholism's quantity and frequency questions

1. On average, how many days per week do you drink alcohol?
2. On a typical day when you drink, how many drinks do you have?
3. What is the maximum number of drinks you had on any given occasion during the last month?