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Correspondence

Knowledge and practice regarding the German and the EASL-EASD-EASO NAFLD-guidelines among members of the German Obesity Society

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Dear Editor,

Nonalcoholic fatty liver disease (NAFLD) is a pathogenetically complex and clinically heterogeneous disease resulting from a diverse interaction of environmental components and a genetic background. It is a systemic condition featuring metabolic, cardiovascular, and (both hepatic and extrahepatic) cancer risk [1,2]. NAFLD is not only a sequelae of diabetes mellitus, obesity, and the metabolic syndrome, but itself is a determinant for the future development of type 2 diabetes mellitus and the metabolic syndrome which has potentially relevant clinical implications for diagnosing, preventing, and treating these conditions [3,4].

NAFLD is the fastest growing cause of chronic liver disease worldwide und its prevalence – which is currently estimated to be 25% in the general population of Europe and the Unites States – is predicted to rise along with the ongoing obesity pandemic with increasing rates of type 2 diabetes and the metabolic syndrome [1]. The annual predicted incident NAFLD cases are 12.5 Mio. in the US and around 2–3 Mio. in Western European countries like Italy, Germany, France, or the United Kingdom resulting in 15–70,000 new annual cases with compensated cirrhosis and 800–4000 cases with hepatocellular carcinoma [5]. NAFLD is particularly prevalent in patients with type 2 diabetes mellitus with prevalence rates of 43–70% [6] and represents an important economic burden for European countries: Subjects with sonographic fatty liver disease and increased serum alanine aminotransferase levels have 26% higher overall health-care costs at 5-year follow-up [7].

Due to these major multifaceted clinical implications, the European Association for the Study of the Liver (EASL), the European Association for the Study of Diabetes (EASD), and the European Association for the Study of Obesity (EASO) have recently published interdisciplinary guidelines, which provide recommendations on systematic screening for NAFLD in individuals with high metabolic risk [8]. These guidelines accompany national guidelines provided by the German Society of Gastroenterology (DGVS) [9]. Both guidelines recommend imaging techniques, especially ultrasound, as the first step towards detecting hepatic steatosis. The German guidelines recommend the NAFLD fibrosis score and transient elastography (TE) for further risk stratification and criteria for a specialist referral [9], while the international guidelines recommend risk stratification according to the presence or absence of elevated liver enzymes. In case of normal liver enzymes, serum fibrosis markers like the NAFLD fibrosis score, Enhanced Liver Fibrosis (ELF) test, or fibrosis 4 calculator (FIB-4) should guide further clinical management [8]. However, although these diagnostic work flows have been established, it is critical to investigate how they are used in clinical practice and what particular limitations arise. Ultrasound, transient elastography, and serum fibrosis markers may be well known and – with limitations – be available in the community of hepatologists, however, it is of major importance how non-hepatologists like diabetologists or heath care providers (HCP) specialized in the treatment of obesity comply with the guideline recommendations as these colleagues will see the majority of patients with diabetes mellitus, obesity, and metabolic syndrome potentially at risk for advanced NAFLD in contrast to hepatologists, who may only see the tip of the iceberg after referral of pre-selected individuals.

We therefore sent an internet-based questionnaire (Lime Survey) to assess knowledge and practice regarding the German and the EASL-EASD-EASO NAFLD-guidelines [8,9] to all physicians of the German Obesity Society. The questionnaire was set up with "forced choice" options, meaning participants could not leave out questions other than those that followed from one of the answers provided. Participants provided answers on a 5-point Likert scale. Data analysis was performed using software from the R Development Core Team (2011), version 3.4.1.

The questionnaire was returned by 46/325 (14%) contacted obesity physicians. Of these health care providers, 48% work in private practices and 52% at hospitals. 91% of doctors were board certified with a wide spectrum of medical specialities (17% general practitioners, 20% internal medicine specialists, 11% endocrinologists/diabetologists, 20% visceral surgeons) reflecting the multidisciplinary character of the German Obesity Society and the necessary interdisciplinary approach to successfully treat obese patients.

Baseline characteristics of the answering health care providers were similar to the general structure of the German Obesity Society with 50% of colleagues working in private practice and at hospitals and with 90% of members being board certified (20% general practitioners, 25% internal medicine specialists, 20% endocrinologists/diabetologists, 15% surgeons).

Although the majority (63%) of the respondents correctly estimated the prevalence of NAFLD in patients with obesity, diabetes mellitus, or the metabolic syndrome to be over 50%, this estimate did not influence the knowledge of the EASL-EASD-EASO NAFLD nor the German guidelines: 15% and 44% of physicians reported to have either non-existent or poor knowledge of the guidelines, i.e. only 41% had good knowledge. This knowledge did not correlate

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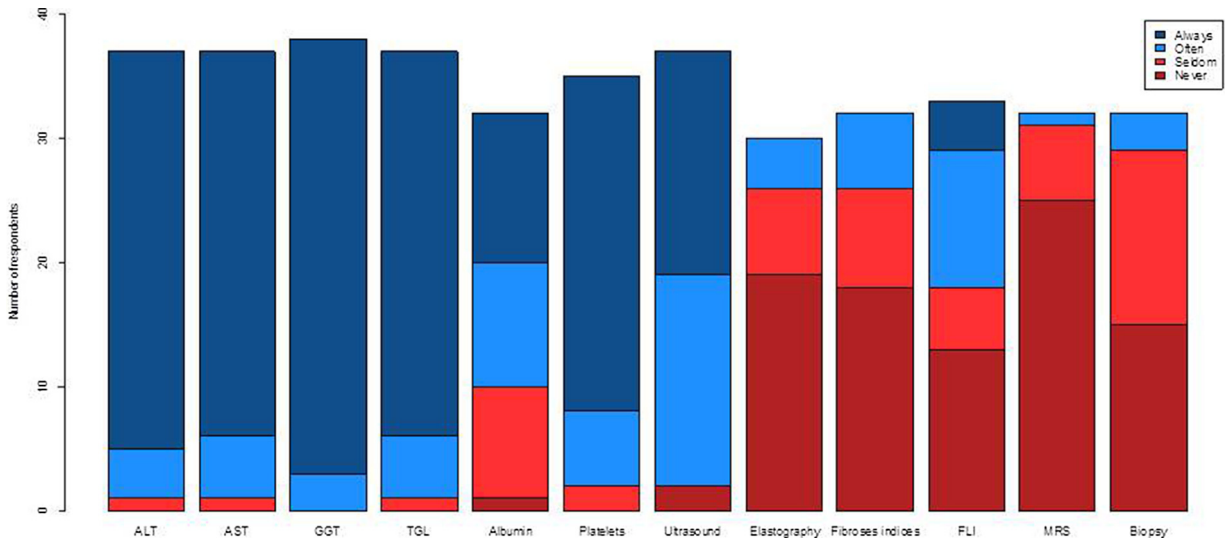

Fig. 1. Use of clinical parameters by physicians specialized in the treatment of obesity.
Abbreviations: ALT – alanine-aminotransferase; AST – aspartate-aminotransferase; GGT – gamma-glutamyl-transferase; TGL – triglycerides; FLI – fatty liver index; MRS – magnetic resonance spectroscopy.

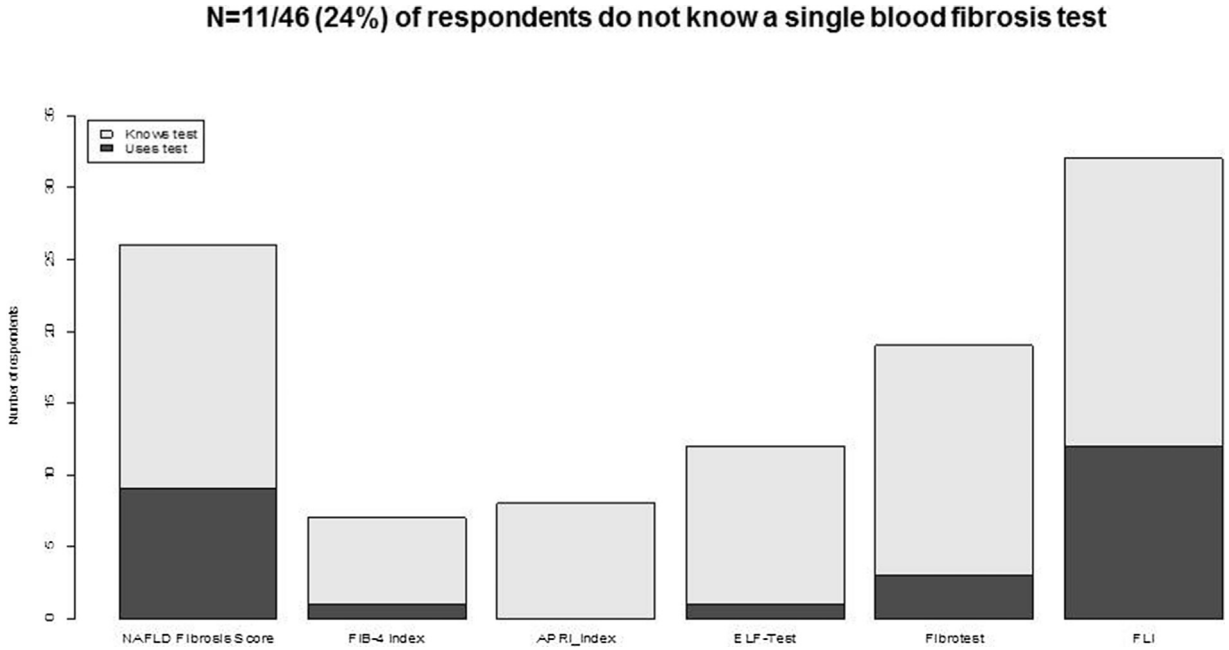

Fig. 2. Knowledge and use of blood fibrosis and steatosis tests. Abbreviations: FLI – fatty liver index.

with place of work, medical speciality, or additional membership in the German Diabetes Society.

67% of obesity physicians responded that they screen regularly for NAFLD. About half (52%) of these physicians reported that they are quite familiar with the guidelines compared to only 20% of those who responded to not screen regularly.

NAFLD screening was usually performed by recording anthropometric and different laboratory parameters. Body mass index, waist circumference, and waist-to-hip ratio were regularly assessed by 98%, 87%, and 63% of physicians, respectively. Alanine aminotransferase (ALT), aspartate aminotransferase (AST), gamma-glutamyl-transferase (GGT), triglycerides, and platelets were almost universally analysed, but much less so albumin (Fig. 1). Abdominal ultrasound was always or often available according to 76% of the respondents. However, among physicians who perform NAFLD screening, 90% use ultrasound on a regular basis, but only 7% elastography.

In contrast, laboratory or ultrasound based characterization of hepatic fibrosis was performed regularly by only 13% and 9% of physicians. Liver biopsy was even more uncommon (7%), magnetic resonance imaging for hepatic steatosis or fibrosis assessment practically unavailable (2%, Fig. 1).

Sub-analysis of different laboratory based fibrosis assays revealed that 24% of the respondents did not know a single blood fibrosis test. Of those familiar with at least one test, the NAFLD fibrosis score and fibrotest were best known (74% and 54%), but only used by 35% and 16% of those respondents who knew the respective test. The NAFLD fibrosis score and fatty liver index were each used in 50% (n = 4/8) of University hospitals compared to 13% (n = 5/38) and 21% (n = 8/38) of non-university settings. The APRI score, FIB-4 index and ELF test were irrelevant in clinical practice (Fig. 2).

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