Tackling the epidemic: the NCEPOD report on alcohol-related liver disease and the Lancet Commission on Liver Disease

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Over the last three decades, the prevalence of chronic liver disease has steadily increased in the UK. Alcohol-related liver disease (ARLD), obesity-related liver disease, and chronic hepatitis B and C infection are the major causes for the rise.[1] Liver disease is now one of the major causes for premature death in the UK and is the only one of the major diseases for which the rates are still increasing.[1,2] In 1999, liver disease surpassed lung cancer and breast cancer as the leading cause of lost years of working life, and is soon set to overtake ischaemic heart disease.[3] Between 1980 and 2013, deaths from liver disease increased fourfold, with 84% of the increase due to ARLD.[4]

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) of patients with ARLD, Measuring the Units, published in 2013, raised concern that the care of patients admitted to hospital with decompensated alcohol-related cirrhosis was frequently poor.[5] The NCEPOD report examined the care of a group of patients who died from ARLD in hospitals in the UK. Among its significant findings were that death was avoidable in over 10% of cases and that only 47% of the patients who died from ARLD received what was deemed by the assessors to be 'good care'. When patients were admitted with decompensated liver disease, opportunities to improve their care by doing simple things, such as optimising fluid management and screening for sepsis, were often missed. Only 2.9% of patients were reviewed by a consultant hepatologist; most patients were cared for by general physicians or luminal gastroenterologists. The report also noted that access to emergency endoscopy (for banding of varices) was poor, and only 25% of hospitals had a dedicated alcohol team in place. The majority of patients had been to hospital at least once in the 2 years prior to the admission when they died, but not enough was carried out to address their harmful drinking at that time. There was a failure to screen for harmful use of alcohol and even when this was identified, patients were often not referred for support. The NCEPOD report made a number of recommendations, including screening for alcohol misuse in patients presenting to hospital services, setting up a consultant-led alcohol service, timely review by a consultant hepatologist, appropriate escalation of care, and the establishment of a toolkit for the acute management of patients with decompensated ARLD.

The Lancet Commission for liver disease in the UK was set up in July 2013, following a meeting on Addressing the Crisis of Liver Disease: Alcohol, Viral Hepatitis, and Obesity, held at the Royal Society of Medicine.[6] The alarming figures from the NCEPOD report made this Commission timely and important. The Commission aims to provide evidence-based recommendations to reduce mortality from avoidable causes and to improve the standard of care for patients with liver disease.[6] Now into its fourth annual report, the Commission has produced eight core recommendations, which echo those of the NCEPOD report.

Where is the UK now? As a response to the NCEPOD's recommendation that a toolkit for acute management of patients admitted with decompensated ARLD be developed, a 'care bundle' has been introduced to guide treatment within the first 24 hours of admission. This care bundle was first piloted in Newcastle upon Tyne Hospitals NHS Foundation Trust in March 2014.[7] A comparison of pre-bundle and post-

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bundle audit data from three English hospitals showed that patients with a completed care bundle were more likely to undergo a diagnostic ascitic tap to exclude spontaneous bacterial peritonitis, have an accurate alcohol history documented and be given prophylactic antibiotics following variceal haemorrhage.[8]

Alcohol-related deaths in England and Wales decreased from a peak of 7,312 in 2008, when the alcohol duty escalator was introduced, to 6,999 by 2012, but increased again in 2016 to 7,630 after abolition of the duty escalator in 2013.[3] A £0.50 minimum price per unit of alcohol would save an estimated 2,930 lives and prevent 49,000 cases of illness each year, with a cumulative health saving of £6.2 billion over 10 years.[9] The Lancet Commission has strongly advocated for minimum unit pricing of alcohol: to date, this is in effect only in Scotland, although the Welsh Assembly has passed a bill that is yet to be enacted.

A total of 55% of all hospitals in England do not have a specialist hepatologist, and 30% do not have a dedicated liver clinic. There is a need for investment not only in workforce and service provision, but also in hepatology training.[10] Guidelines published by The National Institute for Health and Care Excellence on fatty liver disease and the diagnosis of cirrhosis will hopefully improve management of liver disease in primary care.[3] Liver disease often first presents at a very late stage: the Scottish Chief Scientist's Office has commissioned a trial of automatic screening of all patients with abnormal liver function tests for markers of fibrosis, as well as viral and autoimmune serology, which could identify liver disease at a much earlier stage.[4] Mortality in patients with decompensated liver disease is high, yet end-of-life care is generally unplanned, and patients often do not access palliative care services. Some would argue that palliative and end-of-life care is one of the greatest unmet needs in hepatology.[11]

Much needs to be done: the NCEPOD report and the Lancet Commission provide a road map on how to reduce alcohol-related mortality and improve the care of patients with chronic liver disease.

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