KASL Clinical Practice Guidelines: Management of Alcoholic Liver Disease

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In Korea, alcoholic liver disease is the second most common cause of chronic liver disease after viral liver disease, and number of alcohol-related deaths remains high at 9.6 deaths per 100,000 persons per year. Still, Korean culture is lenient towards drinking and the drunken state, as alcohol is considered an important social lubricant for both business and private gatherings. Alcoholic liver disease tends to be thought of as a personal problem, which has led to underestimation of its importance and dwindling academic interest since the advent of antiviral therapy. Given the large amount of worldwide interest and research in alcoholic liver disease, however, there is a need for clinical practice guidelines for the management of alcoholic liver disease, fitted to the Korean healthcare system. This need prompted the Korean Association for the Study of the Liver (KASL) to develop the “KASL Clinical Practice Guidelines for Management of Alcoholic Liver Disease”, based on a systematic approach to reflect evidence-based medicine and expert opinion in internal medicine and psychiatry, with aims of setting clinical practice guidelines for management of alcoholic liver disease and improving public health in Korea.

In 2010, the WHO implemented “Global strategy to reduce harmful use of alcohol” and proposed areas for national action. In Korea, however, cheap pricing of hard liquor and easy accessibility to alcohol have contributed to physical, psychological, social, and economical damage caused by alcohol use. Thus, strategies to reduce harmful use of alcohol in Korea are also addressed in the guidelines.

The Korean version endorsed by KASL was presented at the KASL website, http://www.kasl.org. And the English version which is presented at the 19th Annual Meeting of KASL will be submitted to Clinical and Molecular Hepatology on June, 2013.

Figures included in the guidelines are as follows:
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Figure 1. Total adult per capita consumption, in litres of pure alcohol, 2005 (WHO Global Status Report on Alcohol and Health 2011).

Figure 2. Natural history, spectrum and pathophysiology of alcoholic liver disease.
Severe alcoholic hepatitis
(modified Discriminant Function ≥32 or hepatic encephalopathy)

Liver biopsy if diagnosis is uncertain

Is steroid contraindicated?

No

Prednisolone 40 mg qd for 7 days

Yes

Pentoxifylline 400 mg tid for 28 days

Lille model score ≥0.56 on day 7

No

Prednisolone 40 mg qd for additional 21 days ± tapering

Yes

Stop prednisolone
Consider liver transplantation

Figure 3. Treatment algorithm of severe alcoholic hepatitis.