Quality standards for the management of alcohol related liver disease

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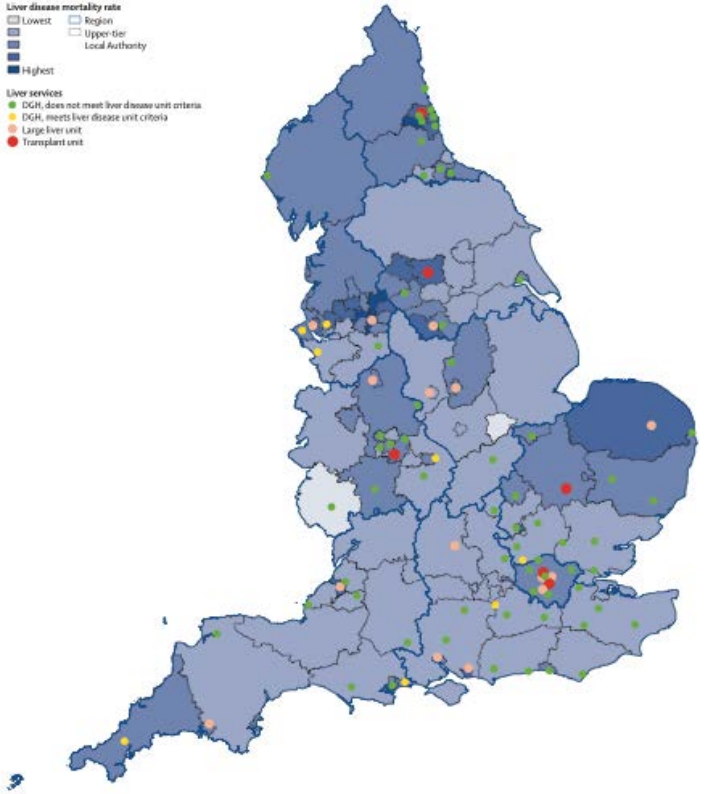
Variation



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Lancet 2015 386

Variation

Table 3 Characteristics of cases by NHS region and 3-year survival

NHS region	Cases (n)	Mean age at diagnosis	Crude incidence*	% HBV or HCV	% who visited specialist centre	First-line HCC treatment†			3-year survival (%)
						Curative intent‡	Other§	None	
East of England	240	68	4.7	17.1	48.4	14.2	16.3	69.6	24.6
London	365	65	5.1	38.1	63.6	27.7	21.9	50.4	40.0
Midlands	350	69	4.3	13.6	52.0	15.9	23.9	60.2	23.9
North East and Yorkshire	340	69	5.0	9.7	56.4	24.3	14.4	61.3	25.2
North West	295	66	5.2	20.8	48.5	20.5	21.2	58.4	23.5
South East	320	68	4.6	19.7	44.6	19.7	22.5	57.8	25.3
South West	200	68	4.7	12.9	32.6	15.8	21.3	62.9	29.7
Total¶	2160	68	4.8	18.6	48.4	20.6	20.5	58.9	28.2

*Per 100 000 population over 18 years of age.
†% of region, any transplant or otherwise first-line treatment.
‡Transplant, resection and ablation.
§Chemotherapy, TACE and radiotherapy.
¶48 cases had no region recorded.
HBV, hepatitis B virus; HCV, hepatitis C virus; NHS, National Health Service; TACE, transarterial chemoembolisation.

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Beecroft S, et al. Frontline Gastroenterology 2023;14:19–24

Guidelines

The effects of clinical practice guidelines on patient outcomes in primary care: a systematic review

Graham Worrall, MB, BS, MSc; Paul Chaulk, MSc; Darren Freake, MSc

Effects of evidence-based clinical practice guidelines on quality of care: a systematic review

M Lugtenberg,[1] J S Burgers,[2] G P Westert[1,3]

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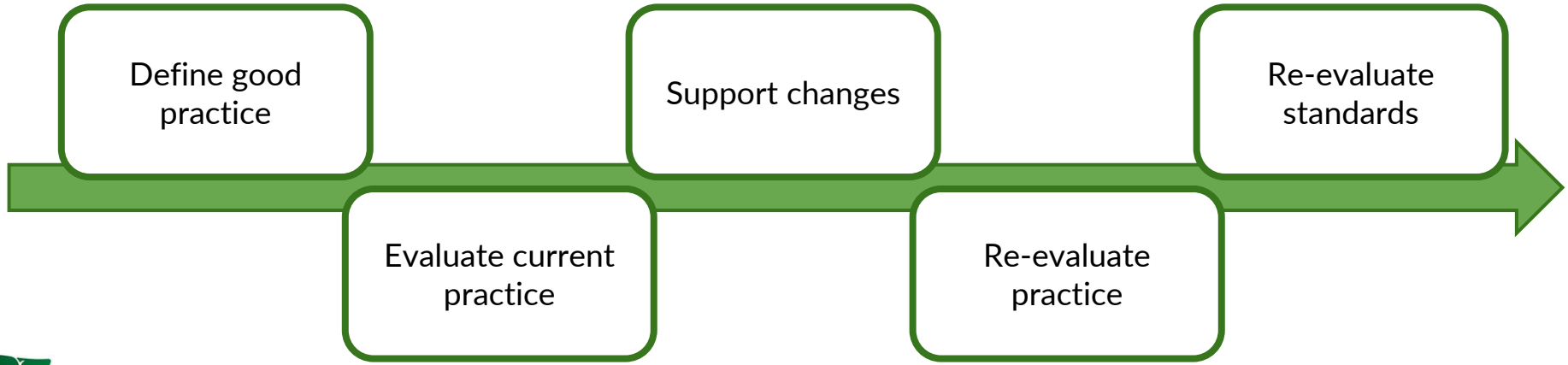
Worral et al Can Med Assoc J 1997;156:1705-12
Lugetenberg et al Qual Saf Health Care 2009;18:385–392

Variation + Quality standards = Better Care



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Background

Quality standard ≠ guideline

Statements to

- support management
- Support audit
- Reduce variation

Not statements about ‘generic’ hepatology practice

Intention to produce 25 - 35 statements about practice

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Quality standards development committee

Working group 1

Working group 2

Working group 3

Writing group

‘Delphi’ partners

Review and express agreement on proposed quality standards

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BMJ Open Gastroenterology

Quality standards for the management of alcohol-related liver disease: consensus recommendations from the British Association for the Study of the Liver and British Society of Gastroenterology ARLD special interest group

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Parker R, et al. BMJ Open Gastroenterol 2023;10:e001221. doi:10.1136/bmjgast-2023-001221

Pre-hospital standards

1. People who are being asked about their alcohol use should have a validated alcohol questionnaire completed to identify any need for intervention

2. Assessment of liver fibrosis should be

a. Offered to people who drink hazardously (35 units/week in women, 50 units/week in men).

b. Considered in people drinking alcohol in excess of maximum recommended levels (14 units/week) who have cofactors for liver disease (eg, obesity).

3. Assessment of hepatic fibrosis should be done using validated non- invasive liver fibrosis markers

4. Patients identified at high risk of advanced fibrosis or cirrhosis should be offered referral for assessment by a gastroenterologist or hepatologist

Hospital standards (1)

1. Patients presenting to hospital with liver disease should be screened for alcohol use disorder (AUD) and an estimation of typical no of units of alcohol per week recorded.

2. Patients admitted to hospital with ALD should be reviewed by a clinician trained in hepatology and the management of alcohol withdrawal within 24 hours of admission.

3.Patients admitted to hospital with ALD and AUD should be assessed by a specialist addiction practitioner during their admission and offered appropriate intervention and referral.

4. Alcohol withdrawal syndrome in patients with ALD with advanced liver disease, especially jaundice and/or encephalopathy, should be treated in a symptom-triggered fashion using a recognised symptom scoring system to avoid overuse of benzodiazepines.

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Hospital standards (2)

5. It should be documented that patients have been advised that complete abstinence from alcohol is associated with better prognosis in ALD and that stopping alcohol entirely should be their goal.

6. Patients presenting with decompensated ALD or AH should be screened for infection

7. All patients with decompensated ALD should have a nutritional assessment

8. A plan for escalation of care in patients with ALD who develop acute- on- chronic liver failure (grades 2 or 3) should be clearly documented.

Hospital standards (3)

9. AH should be diagnosed in keeping with recognised clinical criteria, and patients suspected as having AH but who have confounding factors or do not fulfil all criteria should be considered for liver biopsy

10. Patients with AH should have their prognosis assessed using a recognised prognostic scoring system (GAHS; MELD).

11. Corticosteroid treatment should be considered in patients with indicators of likely beneficial response (GAHS≥9; MELD 21–51; NLR 5–8) and without infection

12. Response to treatment with corticosteroids should be assessed after 7 days and corticosteroid treatment discontinued if there is no response.

Hospital standards (4)

12. Patients should be provided with clear, written information about their liver disease in a manner that they can understand before they leave hospital.

14. The date and time of follow- up appointments should be arranged with patients before they leave hospital.

15. Patients hospitalised with decompensated ALD or AH should be followed up by clinicians with specialist interest in hepatology within 6 weeks of discharge.

Post-hospital standards

1. Patients with ALD with AUD should be offered community- based alcohol support after discharge from hospital.

2. Access to addiction specialists should be available, when indicated, for all patients with decompensated ALD after leaving hospital.

3. Medicines to support abstinence are beneficial and should be continued in primary care after being started in hospital or in alcohol treatment.

4. Patients with ALD with ongoing hepatic failure and a UKELD score greater than 49 should be considered for liver transplant referral if they are abstinent from alcohol.

5. Patients with ALD with an expected survival of less than 12 months should have their condition discussed with palliative care services.

Audit tool

	Numerator	Denominator	Target/setting
Assessment of liver fibrosis			
1. **Assessment of liver fibrosis should be:** a. **offered to people who drink hazardously (35 units/week in women, 50 units/week in men)** b. **considered in people drinking alcohol in excess of recommended levels (14 units/week) who have co-factors for liver disease**	Num indiv patient a valida for h fibr		
Hospital management			
2. **Patients admitted to hospital with ALD should be seen by a liver specialist clinician within 24 hours**	Patien by a spe clinicia 24 ho		

Supporting information

Alcohol-related cirrhosis

You have been diagnosed with decompensated alcohol-related cirrhosis. This leaflet explains what it is, the risks to your health and what will happen after your discharge from hospital.

What is cirrhosis?

Cirrhosis is a stage of liver disease where there is lots of scar tissue in your liver. It affects the whole liver. It is thought to be irreversible. In your case, cirrhosis has developed wholly

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ALERT audit

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