NASH : a welfare disease with emerging questions and adequate answer attempts

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To the Editor,

We read with great interest the Letter of Pieter Vandekerckhove, Brieuc Van Damme and Lieven Annemans (1) and we would like to thank them for this interesting economic but also anthropological and philosophical point of view, which complements perfectly our document (2).

Our goal with the guidance document (2), in line with the quest for quality that characterizes the AGEB Journal editorial line (3), was to increase awareness of the disease among the medical community and draw the attention to this "new" recognized cause of cirrhosis as well as of general (extra-hepatic) complications. We also wanted to stimulate disease case finding and provide adequate tools to evaluate disease severity in targeted patients. Finally, our objective was also to supply treatment strategies for selected patients, if necessary, even if there is currently still no NASH dedicated drug.

The authors ask the important economic questions of the rising costs due to NASH (1). It is of course an important economic problem in the context of expanding welfare diseases. However, we would like to remind that the goal of appropriate screening, information (prevention) and treatment (weight loss strategy, effective drug in the future for patients with advanced disease or at high risk of progression) is to avoid liver transplantation for this indication, reduce cardiovascular mortality and improve quality of life (2).

Other problems do exist with the expansion of the disease and represent a real threat to the optimal non-alcoholic fatty liver disease (NAFLD) management. For example, liver steatosis, which is frequent (25% of the adult population in Belgium), does not equal non-alcoholic steatohepatitis (NASH, which concerns 2.5 to 5% of the population). It is, however, difficult in daily practice to make a clear distinction between those two entities (same patient profile, quite similar blood liver test abnormalities,…). This could lead to alarming information for a high number of patients, sometimes badly advised or trying auto-medication with drugs or compounds without any scientifically proven benefit (and with potential underestimated side effects).

For sure, we agree that it is important to preserve our healthcare system based on solidarity (1). As medical doctors and hepatologists, our role is to give the appropriate information to the population, policy makers, general practitioners, all involved specialties, and provide adequate tools to screen and treat patients without any restriction based on putative individual responsibility. Indeed, NASH could arise in patients as a consequence of genetic predisposition, side effect of another essential treatment (for cancer or for auto-immune disease for example), environmental factors (job with circadian disruption for example) or educational status.

Again, we thank the authors of this Letter (1) for their important contribution to this important debate and welfare discussion.

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Keywords : non-alcoholic steatohepatitis, non-alcoholic fatty liver disease, economy, treatment, society, healthcare.

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Submission date : 22/03/2020
Acceptance date : 27/03/2020