Practical management of the increasing burden of non-alcoholic fatty liver disease

We have read with interest the comprehensive review article by Mouralidarane and colleagues¹ that details current evidence on the pathogenesis and management of non-alcoholic fatty liver disease (NAFLD). We feel we have two important questions that relate to the author's algorithms. Firstly, figure 2 illustrates that after an enhanced liver screen is performed and there is evidence of hepatitis B virus (HBV), hepatitis C virus (HCV) or a focal liver lesion, then referral to a liver unit is appropriate. However, if there is no evidence of HBV, HCV or a focal liver lesion, then the algorithm passes on to figure 3, which states that if the patient's liver function tests are abnormal (alanine aminotransferase $\times 2$ >upper limit of normal) 3–4 months after initial baseline blood tests, then a variety of NAFLD related measures should be targeted (eg, waist circumference, lifestyle changes, etc). Despite this, there is no mention in either algorithm regarding the handling of positive tests for liver diseases, such as haemochromatosis, autoimmune hepatitis, primary biliary cirrhosis, primary sclerosing cholangitis or Wilson's disease, which would all equally warrant referral to a liver unit. Secondly, the authors quote the Dionysos study² in which 55% of Italian adults had normal transaminase levels. Therefore, we feel that for completeness, figure 1 should include radiological suspicion of fatty liver disease in the problem section. Ultrasound imaging is now a readily available diagnostic modality that is increasingly detecting

patients with fatty liver disease and hence NAFLD. Ultimately, ultrasound may provide a valuable means of identifying those NAFLD patients who otherwise may have normal liver function tests and thus allow appropriate referral of such patients.

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