Management of severe acute alcoholic hepatitis in France : results of a national survey

J.F.D. Cadranel (1) ; T. Thévenot (2) ; T. Dao (3) ; J.-B. Nousbaum (4) ; M. Rudler (5) , N. Carbonell (6) , A. Coilly (7) , , H. Zougmoré (1), K. Bideau (8) , P. Mathurin (9) , A. Abergel (10) , E. Nguyen-Khac (11) , C. Barrault (12) , T. Paupard (13) , P. Sogni (14) , F. Durand (15) , C. Lemaitre (16) , V. de Lédinghen (17) , F. Heluwaert (18) , J.-P. Richardet (19) , G.P Pageaux (20) ; C. Costentin (21) , J.-P. Bronowicki (22) , J. Boursier (23) , R. Smadhi (1) , A. Heurgué (24) , M. Medmoun (1) , G. Fantognon (1) , P. Pulwermacher (1) T. Le Magoarou (1)

(1)Creil ; (2) Besançon ; (3) Caen ; (4) Brest ; (5) Paris-Pitié ; (6) Paris-Saint Antoine (7) Villejuif ; (8) Quimper ; (9) Lille ; (10) Clermont-Ferrand ; (11) Amiens ; (12) Créteil-CHIC ; (13) Dunkerque ; (14) Paris-Cochin; (15) Clichy; (16) Le Havre ; (17) Bordeaux-Pessac ; (18) Annecy ; (19) Créteil-Henri Mondor; (20) Montpellier ; (21) Grenoble ; (22) Nancy ; (23) Angers ; (24) Reims . ANGH-AFEF-SNFMI-CREGG

Introduction:

Since 2010 (1), little data has been available in France on the management of severe acute alcoholic hepatitis (AAH). In order to obtain a current "map" of the management of severe HAS in France, a practice survey was carried out from 04/2022 to 07/2023.

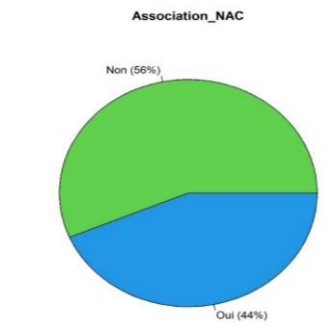
Respondents and Methods:

A Google questionnaire pre-established by a working group was sent to all general hospital hepatogastroenterology departments (CHG), university hospital hepatology departments, SNFMI and CREGG members. Results are expressed as means ± SD. Data analyzed: demographics, type of practice (CHU, CHG), predominant specialty, experience, number of AAH treated per center with corticosteroids (C) or corticosteroid N-acetylcysteine (NAC). Existence of an AAH treatment protocol. Systematic use of transjugular liver biopsy (LB), on-site LB, delay in obtaining results. Treatment: use of C alone or C-NAC. Screening for bacterial infections, use of antibiotic therapy (ATB), in the event of infection: delay in starting treatment for AAH. Use or non-use of C in antigen-positive HBs patients (with or without pre-emptive treatment). Interruption of C in case of intermediate Lille score at D7. Indication for transfer to a liver transplant centerTranslated with DeepL.com (free version)

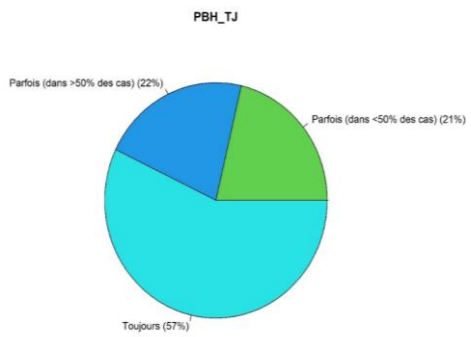
Results:

465 respondents (R): 40 years (12.5); 50% M, 50% F, CHU 53.3%, CHG 46.7%, hepatologists 57%, gastroenterologists 39%, juniors 21%. Number of HAA treated with corticoids or corticosteroids NAC 25 (0 to 300); the number of HAA treated in CHU was higher than in CHG: 34 (29), CHG 15.4 (13.4), $p < 0.001$. Treatment protocol for severe HAA, 62% (CHU) vs. 42% (CHG), $p < 0.001$. PBH systematically performed: CHU 98% vs. other 50%, $p < 0.001$. Time to LB (days): 3.4 (CHU) vs 4.9 (CHG), $p < 0.001$. Nutritional status was assessed by 98% of R. A systematic thoracic CT scan was requested by 34% of R in case of suspected pulmonary infection (CHU versus CHG ns); 83% of R waited 4 days (2-6) to start C treatment in case of documented infection. Treatment: C alone 70% of R (CHU vs CHG ns), NAC use: CHU 40% vs CHG 47% (ns).

Treatment protocol for alcohol withdrawal syndrome: 86.3% CHG vs 76.3% CHU ($p < 0.01$). C discontinuation in case of intermediate Lille score at D7: 80% CHG vs. 77% CHU; ns. 69% of R's were responsible for initiating treatment. 68.2% of R's were responsible for initiating treatment; 64.7% in CHU vs 72.3% (CHG) (p=0.103); 80.6% senior doctors vs 20.4% junior doctors (p<0.001). 62% of R's used preemptive treatment before C in case of positive HBs antigen; 59.4% in CHU vs 65% in CHG (p=0.004) and 76% did a oesogastroduodenal fiberscopy if there had been none previously, 77% in CHU vs 75% CHG (p=0.782).



Distribution of respondents according to the combination of NAC and corticosteroids, in the case of dual therapy



Distribution of respondents according to whether PBH is performed in cases of suspected HAACHU 98% versus CHG 50%: $p < 0.001$

Discussion:

The results of this national practice study carried out in a large sample of physicians practicing in and outside university hospitals show a disparity in the use of LB in cases of suspected severe HAA, with 50% of non-hospital R's not using LB, mainly because of the absence of local possibilities. Dual C-NAC therapy is used quite frequently. This study provides an update on the management of severe AAH in France.

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(1) E.Nguyen-Khac et al. J Hepatol 2010 (abstract)