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BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

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LIVER DISEASE

You'll see more focus on managing **n**on**a**lcoholic **f**atty **l**iver **d**isease (NAFLD)...partly due to new guidelines.

It's being called a "sleeper epidemic." About 1 in 4 patients have this fat buildup in the liver...but most don't have symptoms.

NAFLD often goes hand in hand with CV risk factors, such as insulin resistance or diabetes...obesity...and dyslipidemia.

And at least 1 in 7 of these patients have **n**on**a**lcoholic **s**teato**h**epatitis (NASH)...a more aggressive form of NAFLD that can lead to liver fibrosis, cirrhosis, or liver cancer.

The tough part is that there's not good evidence that meds decrease the risk of cirrhosis, liver transplant, or death.

Reinforce that weight loss is the most important treatment. A loss of over 5% reduces liver fat...over 10% can reverse fibrosis.

Optimize meds for diabetes, dyslipidemia, hypertension, etc.

Reassure that statins are safe in NAFLD...even in NASH.

For NASH, recommend pioglitazone or injectable semaglutide (*Ozempic*, Wegovy). These reduce liver fat and slow fibrosis progression...regardless of type 2 diabetes.

Suggest pioglitazone up to 30 mg/day...higher doses don't add benefit. But caution about edema and weight gain...and avoid it in heart failure.

Otherwise, advise titrating *Ozempic* or *Wegovy* toward max doses. There's not much evidence with other GLP-1 agonists.

But consider downsides...such as GI side effects, rare pancreatitis, and cost of about $1,000/month. Expect prior auths.

Point out that SGLT2 inhibitors (*Jardiance*, etc) reduce liver fat in type 2 diabetes...but there aren't data on liver fibrosis.

Tell patients not to rely on milk thistle to help NAFLD.

And don't jump to vit E. Taking 800 IU/day might reduce liver fat and inflammation in patients with NASH withOUT diabetes...but there's no evidence in other patients. Plus some evidence suggests that doses of 400 IU/day or above are linked with CV risk.

(For more on this topic, see Clinical Resource #380706 at PharmacistsLetter.com.)

Cusi K, Isaacs S, Barb D, et al. American Association of Clinical Endocrinology Clinical Practice Guideline for the Diagnosis and Management of Nonalcoholic Fatty Liver Disease in Primary Care and Endocrinology Clinical Settings: Co-Sponsored by the American Association for the Study of Liver Diseases (AASLD). Endocr Pract. 2022 May;28(5):528-562.

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See LEADER NOTES for answers to discussion questions.

DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. **What are the new guidelines for management of nonalcoholic fatty liver disease (NAFLD)?**

ANALYSIS OF NEW GUIDELINE

2. **What are the criteria for development or evaluation of practice guidelines?**

3. **Are the new guidelines evidence based? Is evidence linked to recommendations with a strength of recommendation grading system?**

4. **Are the guidelines unbiased and representative of a wide range of clinicians?**

5. **Are the guidelines based on outcomes important to patients?**

See LEADER NOTES for answers to discussion questions.

6. **Are the interventions proposed in the guidelines feasible in all practice settings?**

7. **Has this guideline been prospectively validated?**

8. **What are the major guideline recommendations for treatment of NAFLD, and what are considerations about these recommendations?**

9. **Are the guidelines expressed in terms we care about and can use?**

HOW SHOULD THE NEW FINDINGS CHANGE CURRENT THERAPY?

10. **Do the guidelines change your practice? How?**

See LEADER NOTES for answers to discussion questions.

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

RM is a 57-year-old Black male with a past medical history significant for hypertension, hyperlipidemia, diabetes, and non-alcoholic steatohepatitis (NASH) who presents for a routine follow-up. You note that his blood pressure is well controlled today at 119/61 mmHg on carvedilol 3.125 mg twice daily and lisinopril 20 mg daily. He is also taking metformin 1,000 mg twice daily for his diabetes and atorvastatin 40 mg daily for his hyperlipidemia. Review of recent pre-visit lab work reveals an elevated A1c of 8.7%.

RM is interested in making lifestyle changes to help with weight loss and control of chronic medical conditions and asks you for specific recommendations.

11. What lifestyle recommendations should you make for RM?

RM returns to your office 3 months later having lost 10 lb. You celebrate his success! His lab work indicates that his A1c is improved, but still elevated at 7.9%.

12. What medication adjustments do you now consider for RM?

RM elects to start subcutaneous semaglutide. You provide teaching on dosing and administration and agree to see him back in 1 month to reassess. He returns in a month having lost an additional 5 lbs. He is tolerating the medication well with limited side effects. At this visit, he expresses concern about his cholesterol medication and its effect on his liver.

13. How do you counsel RM on his statin use, as well as any OTC medications that may affect his liver?

See LEADER NOTES for answers to discussion questions.

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Additional Pharmacist's Letter Resources available at PharmacistsLetter.com

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Weight Loss: Helping Your Overweight and Obese Patients. Pharmacist's Letter and Prescriber's Letter May 2021.
Weight Loss Products. Pharmacist's Letter and Prescriber's Letter. August 2021.
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Bariatric Surgery and Medication Use. Pharmacist's Letter and Prescriber's Letter. March 2018.

See LEADER NOTES for answers to discussion questions.