



**EUROPEAN ALCOHOL POLICY
CONFERENCE
BUILDING CAPACITY FOR ACTION
Barcelona, 3RD-5TH April 2008**

Alcohol and liver disease

Nick Sheron, , United Kingdom
Nick.Sheron@soton.ac.uk

Deaths from liver disease are increasing markedly in some parts of Europe, notably the UK and Finland, but have decreased in others. The relationship between liver deaths and overall alcohol consumption is very tight but varies between countries presumably as a result of other genetic, social and cultural factors, so for example Finland has relatively more deaths than France at a given level of alcohol consumption whereas in Ireland mortality figures are lagging way behind the increases in consumption. The overall relationship is sigmoid – perhaps reflecting the sigmoid risk curve for consumption. This presentation will cover the UK clinical experience of alcohol related liver disease, with conclusions that can be applied more universally.

The development of alcohol related liver cirrhosis is a completely silent process with gradual scarring fibrosis leading to end stage cirrhosis over a period of 10-20 years. During this time standard liver tests may be normal but newer test of fibrosis can pick up disease at an early stage. The usual clinical presentation of cirrhosis is as a dramatic and often fatal illness – with a massive internal haemorrhage, the development of fluid in the abdomen or jaundice from acute alcoholic hepatitis. Overall alcohol related cirrhosis is fatal in half of cases, and of these half die before they have a chance to stop drinking, for those who abstain the survival curve is flat after 2 years. Although some subjects have severe alcohol dependence many do not and can be classified as controlled heavy social drinkers most of whom have no indication that they are at risk. Although the treatment of cirrhosis in hospital has improved, the in hospital mortality has not changed much in the last 30 years, and so if liver deaths are to be reduced the key is to prevent admissions with end stage cirrhosis by reducing heavy social alcohol consumption or by detecting liver disease and intervening at an earlier stage.

Surprisingly there is quite widespread ignorance amongst clinicians of the evidence based policy measures that are capable of reducing alcohol related liver deaths. So while there is a very tight correlation ($R=0.98$, $p<0.0001$) between UK liver deaths and the affordability of alcohol, there have not yet been the letter writing campaigns from hepatologists that were so influential early in the debate on smoking when the chest doctors became involved. The key to reducing liver deaths is to persuade the UK government to gradually reduce the affordability of alcohol with a general increase in alcohol taxation, while at the same time to begin to fund alcohol treatment, intervention and prevention services with same level of funding currently given to services for misusers of illegal drugs, a fair and effective solution which will impact on

alcohol related harm from all causes. The various Royal Colleges, learned societies and NGO's dealing with alcohol related harm have come together to form the Alcohol Health Alliance UK in order to try and influence government policy towards solutions based on the independent peer reviewed evidence as opposed to the suggestions of industry lobbyists.