Clinical diagnosis and treatment of alcoholic liver disease

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The Asia-Pacific region has a high prevalence of viral hepatitis and hepatocellular carcinoma (HCC). Affordable alcohol and changes in life style and drinking behaviorresult in increasing cases of hospitalization for alcoholic liver disease (ALD). Ethanol abuse is not uncommon among patients with chronic viral hepatitis. Steatosis, apoptosis, necrosis and fibrosis are the major components of hepatic injury. Based on the histological changes, ALD was classified as steatosis, alcoholic hepatitis, alcoholic fibrosis, alcoholic cirrhosis, and alcoholic hepatitis on cirrhosis. Patients with alcoholic hepatitis often have marked hepatomegaly, increasing hepatic arterial flow, leukocytosis and a mild degree of fever. Mortality from alcoholic hepatitis has decreased over the last decade. Two-thirds of patients had cirrhosis regardless of patient groups and coexistent viral hepatitis. Early identification of cirrhosis is important to predict mortality. Noninvasive diagnosis of hepatic fibrosis with transient elastography is a recent interest with some limitations. The annual incidences of HCC were significantly higher in cirrhotic patients with HBV infection and alcoholism than those in patients with HBV infection or alcoholism alone.Antiviral nucleos(t)ides therapy significantly reduces the incidence of HCC in alcoholic cirrhotic patients with concomitant viral hepatitis B infection.Abstinence and nutrition improve long-term survival rates. Anti-inflammatory therapies including corticosteroids and pentoxifylline are current interests in treating severe alcoholic hepatitis. G-CSF improves liver regeneration and 3Ms survival in alcoholic hepatitis. Mortality from alcoholic hepatitis has decreased over the last decade. Liver transplantations for alcoholic cirrhosis are increasedover last two decades. It is thus important to identify alcoholic hepatitis and alcoholic cirrhosis early to offer early management to improve survival.