

LIVER DISEASE IN SOUTH AFRICA



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Liver disease, although common, is frequently clinically silent, with patients often only being picked up on routine screening for insurance purposes or when donating blood, or if they present unexpectedly with complications of cirrhosis. Viral hepatitis and alcoholic liver disease are well-known causes of liver dysfunction. Other important causes such as drug-induced hepatitis, non-alcoholic fatty liver disease and auto-immune liver disease as well as metabolic liver diseases such as haemochromatosis and Wilson's disease need to be considered in the differential diagnosis of the patient presenting with hepatocellular disease. In patients presenting with a cholestatic picture, it is important to remember that there are other causes besides gallstones, such as primary sclerosing cholangitis, primary biliary cirrhosis and increasingly the diagnosis of vanishing bile duct syndrome associated with drugs needs to be considered. Unless these more uncommon forms of liver diseases are considered and looked for, the chance to treat appropriately is missed and the end result is chronic liver disease with its consequent complications.

We are dedicating this Liver issue of *CME* to Professor Ralph Kirsch, Head of the MRC-UCT Liver Research Centre and Head of Medicine at the University of Cape Town, who is retiring at the end of 2005. Professor Kirsch has been instrumental in training many of the hepatologists in South Africa and has played an extremely important role in raising the awareness of liver disease, particularly the need for universal hepatitis B vaccination in a country such as South Africa, where hepatitis B is endemic. It is largely due to Professor Kirsch that hepatitis B became part of the immunisation programme in 1995. This will have long-term beneficial effects in decreasing the incidence of hepatitis B within South Africa and ultimately the risk of hepatocellular carcinoma.

Viral hepatitis remains a common cause of hepatitis and this is discussed in the chapter on acute and chronic viral hepatitis. The treatment options for both hepatitis B and C have significantly increased over the past 5 years. We now have the options of standard interferon, pegylated interferon and nucleoside analogues for the treatment of hepatitis B. The efficacy of treatment for hepatitis C has significantly changed with sustained viral responses ranging between 40% and 50% for genotype 1 and as high as 80 - 90% for genotypes 2 and 3.

Non-alcoholic fatty liver disease is probably the commonest cause of asymptomatic abnormalities in liver function tests in patients in whom other causes have been excluded. The incidence may be as high as 24% in some populations and generally the prevalence is increasing together with rising prevalence of obesity. As many as 80% of subjects with non-alcoholic fatty liver disease have evidence of metabolic syndrome and it is important to realise that patients with non-alcoholic fatty liver disease may progress to cirrhosis.

The diagnosis of auto-immune hepatitis is one of exclusion of all other forms of chronic hepatitis. It should be considered in patients, especially females, presenting with transaminitis with negative viral markers and no history of exposure to drugs or hepatotoxins. It is important to diagnose autoimmune hepatitis early and treat

appropriately with steroids and azathioprine. Late diagnosis and treatment will lead to patients presenting either in subfulminant liver failure or established cirrhosis. In those patients with autoimmune hepatitis who have biochemical evidence of bile duct injury, overlap syndromes with primary sclerosing cholangitis and primary biliary cirrhosis should be considered.

Drug-induced hepatitis is another condition which is frequently not considered and it is important to take an extremely detailed drug history including any homeopathic medications, herbal remedies or over-the-counter medications which the individual patient may not necessarily consider hepatotoxic. It is important that all potentially hepatotoxic medications are stopped while the patient is being investigated for abnormal liver enzymes.

In the chapter on management of chronic liver disease, various management options are discussed, but it is important to realise that all patients with chronic liver disease presenting with complications should be considered for liver transplantation. Liver transplantation is no longer experimental; survival figures are excellent, with 1-year survival figures being greater than 80% and 5-year survival figures being greater than 70%.

In patients presenting with obstructive jaundice the most common causes include common bile duct stones and carcinoma of the head of pancreas. Biliary obstruction, however, may be confused with intrahepatic cholestasis, leading to unnecessary endoscopic or surgical procedures. Ultrasound followed by MRCP and if necessary ERCP or PTC is the appropriate order of investigation.

Lastly, we included an article on the diagnosis of porphyria. Porphyria is common in South Africa and the MRC-UCT Liver Research Centre at the University of Cape Town was involved in the discovery of the gene and principal mutation underlying the high frequency of variegate porphyria in South Africa. Two new techniques have greatly improved and simplified the diagnosis of porphyria in South Africa over the last 10 years – the advent of R59W gene testing for variegate porphyria and plasma porphyrin fluoro-scanning, both of which can be performed on a single blood sample. However, it is important to realise that demonstration of specific mutations in the appropriate gene identifies porphyria, but gives no indication of disease activity.