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**Liver transplantation and non-alcoholic fatty liver disease**

Zezos P *et al.* Liver Transplantation and NAFLD

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**Abstract**

Non-alcoholic fatty liver disease (NAFLD) is an important health problem worldwide. NAFLD encompasses a histological spectrum ranging from bland liver steatosis to severe steatohepatitis (nonalcoholic steatohepatitis, NASH) with the potential of progressing to cirrhosis and its associated morbidity and mortality. NAFLD is thought to be the hepatic manifestation of insulin resistance (or the metabolic syndrome); its prevalence is increasing worldwide in parallel with the obesity epidemic. In many developed countries, NAFLD is the most common cause of liver disease and NASH related cirrhosis is currently the third most common indication for liver transplantation. NASH related cirrhosis is anticipated to become the leading indication for liver transplantation within the next one or two decades. In this review, we discuss how liver transplantation is affected by NAFLD, specifically the following: (1) the increasing need for liver transplantation due to NASH; (2) the impact of the increasing prevalence of NAFLD in the general population on the quality of deceased and live donor livers available for transplantation; (3) the long term graft and patient outcomes after liver transplantation for NASH, and finally; and (4) the *de novo* occurrence of NAFLD/NASH after liver transplantation and its impact on graft and patient outcomes.

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**Key words:** Liver transplantation, non-alcoholic fatty liver disease, hepatic steatosis, steatohepatitis, liver cirrhosis, metabolic syndrome, insulin resistance, obesity

**Core tip:** Nonalcoholic steatohepatitis(NASH) related cirrhosis is anticipated to become the leading indication for liver transplantation within the next one or two decades. In this review, we discuss how liver transplantation is affected by non-alcoholic fatty liver disease (NAFLD), specifically the following: the increasing need for liver transplantation due to NASH; the impact of the increasing prevalence of NAFLD in the general population on the quality of deceased and live donor livers available for transplantation; the long term graft and patients outcomes after liver transplantation for NASH, and, finally; the *de novo* occurrence of NAFLD/NASH after liver transplantation and its impact on graft and patient outcomes.

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**INTRODUCTION**

The term non-alcoholic fatty liver disease (NAFLD) covers a wide spectrum of non-alcohol related, fatty liver disorders, ranging from bland steatosis (NAFL, non-alcoholic fatty liver) to severe steatohepatitis (nonalcoholic steatohepatitis, NASH) (Figure 1). NAFL is thought to be a benign condition, characterized by the presence of hepatocyte steatosis without evidence of hepatocellular injury or fibrosis. Thus, NAFL is, in general, believed not to progress to relevant liver disease. In contrast, NASH is histologically characterized by hepatocyte damage (*e.g.,* ballooning) and inflammation with the potential to progress to fibrosis and cirrhosis, and its associated morbidity (including hepatocellular carcinoma) and mortality[1].

NAFLD is associated with obesity, type 2 diabetes mellitus, dyslipidemia, and the metabolic syndrome. It is presumed that the underlying common pathophysiology among these conditions is insulin resistance (IR) and that NAFLD is the hepatic manifestation of IR[1-3].

Not too surprisingly, patients with NAFLD (NAFL and NASH) have an increased mortality due to cardiovascular disease, while liver-related mortality is, in addition, increased in patients with NASH[1,4,5].

In parallel with the obesity epidemic, the prevalence of NAFLD is increasing worldwide. Thus, it is estimated that NASH will become the most common cause of advanced liver disease within the next ten to twenty years, and that NASH-related end-stage liver disease will become the most common indication for liver transplantation[6]. In addition, the increasing prevalence of NAFLD in the general population, also affects the presence of steatosis in deceased and live donor livers available for transplantation. Furthermore, liver transplantation for NASH related end-stage liver disease, does not improve factors (such as IR) predisposing to NAFLD. Thus, these recipients are at risk for recurrence of NAFLD in the graft. Finally, the prevalence of IR is high after liver transplantation for any (also non NAFLD related) indications, and these patients may develop *de novo* NAFLD in the graft (Figure 2). In the following, all the above aspects are reviewed in sequence.

**NASH RELATED END-STAGE LIVER DISEASE AS INDICATION FOR LIVER TRANSPLANTATION**

As mentioned above, the prevalence of NAFLD is increasing worldwide in parallel with the obesity epidemic. It is estimated that the prevalence of NAFLD in the adult US population is 30%-40%, while studies from other parts of the world report a prevalence ranging from 6% to 35% (median approximately 20%)[6]. Furthermore, it has been estimated that 15%-20% of patients with NAFLD have NASH. This translates into a NASH prevalence in the general population of 3%-5%. Thus, millions of people are at risk of their liver disease progressing to cirrhosis, and potentially requiring liver transplant (LT)[7]. A more recent study from the US observed an even higher prevalence of NAFLD and NASH in the general population (46% and 12%, respectively), and 2.7% in the entire cohort had established, advanced NASH related liver fibrosis, leading to an estimated > 2 million US adults with NASH related, advanced liver disease[8]. The prevalence of NAFLD increases to 70%-90% among patients in high risk populations such as the morbidly obese or diabetics[1,6,8].

According to the scientific registry of transplant recipients (SRTR) in the United States[9], NASH related cirrhosis is currently the third most common indication for liver transplantation surpassed only by hepatitis C virus (HCV), and alcoholic related cirrhosis. During the last 10 years there was a substantial increase in the proportion of transplants performed for NASH, from 1.2% in 2001 to 9.7 in 2009. In another recent analysis, using the united network for organ sharing (UNOS) database, Kemmer *et al*[10] reported that 7.7% of all adult LT recipients had a diagnosis of NASH-cirrhosis during the period 2007-2010. They also found a steady increase in LT for NASH related end-stage liver disease from 5.1% in 2007 to 7.5% in 2010, which held true for all age groups. Furthermore, NASH-cirrhosis was the most common non-malignant indication for LT in patients older than 65 years, whereas it was the third indication for LT in patients younger than 65 years.

Based on organ procurement and transplantation network data as of November 1, 2013, 16629 patients were registered on the waiting list for liver transplantation in the US. NASH cirrhosis was the indication for 1427 of these patients (8.5%), and cryptogenic cirrhosis (CC) for another 954 patients (5.7%). Taking into account that the majority of cryptogenic cirrhosis is considered to be secondary to unrecognized NASH[11,12], NASH related end-stage liver disease is likely the indication for liver transplantation in more than 10% of the patients currently listed in the US (Table 1).

Collectively, these observations indicate that NASH is a rapidly growing, in fact, the only growing indication for liver transplantation in the US.

**IMPACT OF NAFLD ON DONOR LIVERS AVAILABLE FOR TRANSPLANTATION**

The increasing prevalence of NAFLD in the general population translates directly into an increasing prevalence of NAFLD in both, potential deceased and live liver donors. Graft steatosis, in turn, affects both, the quality and the quantity of donor livers available for transplantation[13-16].

Thus, it is well known that primary graft non-function, primary graft dysfunction/delayed graft function, and, consecutively graft outcome, are associated with graft steatosis[15,16]. Upon reperfusion, steatosis induces microcirculatory and cellular changes in the liver graft potentially leading to hepatocyte necrosis. In addition, the regeneration potential of steatotic livers is impaired[17-19].

Compared to microvesicular steatosis, macrovesicular steatosis renders livers more vulnerable to injury and cell death[20]. In addition, mild steatosis (< 30%) is associated with less postoperative complications than more severe degrees of steatosis (> 30%)[13,14,21]. A recent study using UNOS data showed that the presence of more than 30% of macrovesicular steatosis was an independent risk factor for impaired 1-year graft survival[16].

The gold standard for assessing the severity and type of steatosis in a potential donor liver remains the liver biopsy. Routine imaging modalities (ultrasonography, computed tomography or magnetic resonance imaging) are not sensitive and precise enough to quantitate steatosis below 30%, and cannot discriminate between micro- and macrovesicular steatosis. Unfortunately, waiting for the result of a liver biopsy prior to decision making regarding accepting a deceased donor organ, will unduly prolong cold ischemia time and is therefore not feasible in most instances (and a frozen section is notoriously inadequate for this purpose).

For live liver donation, most programs exclude donors with macrovesicular steatosis > 10%-15%[22,23]. Noninvasive preoperative evaluation of living donors for liver steatosis has its limitations. Some programs therefore perform donor liver biopsies universally, others only in cases where steatosis > 10%-15% can otherwise not be ruled out with reasonable certainty[24]. In a recent study, Ahn *et al*[25] assessed histologically the degree and type of steatosis in a cohort of 492 living liver donors with negative liver US and normal aminotransferase levels. They found that although most of these patients had minimal or mild degrees of steatosis, a few had moderate microsteatosis that had not been detected by imaging.

**LONG TERM OUTCOMES OF LIVER TRANSPLANTATION FOR NAFLD AND NASH**

There are several recent, retrospective, single center series reporting on outcomes after liver transplantation for NASH related end-stage liver disease (Table 2). Malik *et al*[26] compared the outcomes in patients transplanted for NASH cirrhosis with those transplanted for other indications [primary biliary cirrhosis, primary sclerosing cholangitis (PSC), alcoholic liver disease and HCV]. Early mortality in NASH recipients was increased, but the 5-year mortality was similar to patients transplanted for other indications. Infection was the main cause of death (50%) in the NASH, but not the control group. Recipients characterized by NASH cirrhosis, older age (> 60 years), higher BMI (> 30 kg/m2), pre-LT diabetes mellitus, and hypertension had 1-year post-transplant mortality of 50%.

Bhagat *et al*[27] compared he outcomes of liver transplantation in patients with NASH cirrhosis and alcoholic cirrhosis (ETOH), and found that the overall and cardiovascular mortality was numerically – albeit not significantly - increased in the NASH group. Barrit *et al*[28] reported that NASH cirrhosis as indication for LT is an independent factor associated with early (30-d) post-LT mortality,hazard ratio 8.96 (95%CI: 1.06-75.8), *P* = 0.04].

Two large national US studies addressing outcomes of LT for NASH cirrhosis were recently published. Charlton *et al*[9] used the SRTR database, Afzali *et al*[29] the UNOS database. Both studies found that the post-LT survival of NASH recipients was excellent (1-year 87.6%, 3-year 82.2%, 5-year 76.7%) and similar to recipients with non-NASH indications. Another recent study by Singal *et al*[30] corroborated that 1-10 year graft and patient survival rates were similar in patients transplanted for NASH, PSC and HBV related cirrhosis, respectively.

Finally, a recent systematic review and meta-analysis compared survival, and causes of death after liver transplantation for NASH and other etiologies[31]. One-, 3- and 5-year patient survivals were similar in NASH and non-NASH recipients. However, cardiovascular (CV) events and sepsis were more frequent as causes of death in NASH recipients. The authors concluded that patients with NASH cirrhosis must be carefully evaluated and selected for transplantation and that post-LT cardiovascular and infection complications must be treated aggressively.

These observations are further corroborated by the study of VanWagner *et al*[32] who found that NASH patients had an increased risk for the development of cardiovascular (CV) events during the first year of liver transplantation compared to ETOH patients (26% *vs* 8%, *P* < 0.001, respectively). The majority of the CV events occurred during the immediate perioperative period, and over 50% of NASH patients with a post-LT CV event had underlying risk factors such as the metabolic syndrome. CV events were the second most common cause of death in NASH recipients (9% *vs* 4% in EtOH recipients), surpassed only by sepsis (11% *vs* 1%).

Collectively, liver transplantation for NASH seems, with the current selection process, to result in excellent overall graft and patient survival (up to 10 years). However, CV events and mortality, as well as sepsis events and mortality seem to be more frequent in recipients transplanted for NASH compared to other indications.

**FATTY LIVER DISEASE AFTER LIVER TRANSPLANTATION**

The prevalence of IR and of other risk factors for NAFLD increase after liver transplantation. Thus, not too surprisingly, both recurrent NAFLD and *de novo* NAFLD in the allograft have been described.

Recurrence of NAFLD in the allograft is common post-LT. Bhagat *et al*[27] reported 33% recurrence of steatohepatitis in biopsy specimens at any time during the first 6 months post-LT in NASH–cirrhosis recipients, but the course of recurrent NASH was benign since none of these patients developed cirrhosis or required re-transplantation during a 10-year follow-up. Yalamanchili *et al*[33] studied the post-LT outcomes in a 257 patients transplanted for CC or NASH cirrhosis. They found that, in the CC/NASH group, the probability of developing hepatic steatosis (NAFL) at 1, 2, 5 and 10 years post-LT was with 8.2%, 13.6%, 24.9%, and 32.9% at all time points higher than in patients transplanted for other indications (3.1%, 5.9%, 9.6%, and 10%, respectively). However, development of NASH in the graft was rare (13 out of 257 patients), advanced fibrosis was uncommon, and overall survival in the CC/NASH group was the same as in patients transplanted for other indications. Finally, Dureja *et al*[34] reported that recurrent NAFLD (predominantly NASH) was histologically found in 39% of recipients transplanted for NAFLD related or cryptogenic cirrhosis associated with the metabolic syndrome. While survival was not affected by NAFLD recurrence, a high frequency of cardiovascular disease and of infection-related morbidity and mortality was noted in patients with NAFLD recurrence.

Collectively, NAFLD seems to recur in at least 1/3 of patients transplanted for NASH cirrhosis. While, NAFLD recurrence does not seem to affect overall graft and patient survival up to 10 years, CV and infection related morbidity and mortality seem to be increased in these patients.

At least 30% of liver transplant recipients for non NAFLD related indications develop IR and/or other risk factors for NAFLD typically within 1-3 years post LT[35-38].There is therefore growing interest in the *de novo* occurrence of post-LT NAFLD in recipients transplanted for non-NAFLD indications[39,40]. Dumortier *et al*[41] studied retrospectively the prevalence of NAFLD in post-LT liver biopsy specimens obtained by protocol biopsies in a population of recipients transplanted for non-NAFLD/CC cirrhosis and assessed the risk factors for NAFLD development. They found that *de novo* liver steatosis developed in 30% and steatohepatitis in 5% of the recipients. Analysis of data revealed that obesity, hyperlipidemia, diabetes mellitus, arterial hypertension, tacrolimus treatment, alcoholic cirrhosis as an indication for transplantation, and pre-transplant liver graft steatosis, were risk factors for the *de novo* development of post-LT NAFLD. The more of these factors were present, the higher was the prevalence of steatosis.

Recent data suggest that the genetic predisposition plays role in the post-LT recurrence of NAFLD. It is well established that the patatin-like phospholipase domain-containing protein 3 (PNPLA3) rs738409-G allele is associated with an increased fat accumulation in the liver, and is a risk factor for developing more advanced liver disease in NAFLD patients[42]. A recent study showed that the presence of the rs738409-G allele of the PNPLA3 in the recipients, but not in the donors, is an independent risk factor for post-LT steatosis[43]. These findings are in keeping with a previous study demonstrating that the presence of the PNPLA-3 rs738409 G- allele was associated with the development of post-LT obesity and diabetes mellitus[44].

**MANAGEMENT OF NAFLD AFTER LIVER TRANSPLANTATION**

Many drugs have been evaluated for treating NAFLD/NASH in the non-transplant setting (*e.g.,* pioglitazone, metformin, vitamin E, pentoxyphilline, ursodeoxycholic acid). Suffice it to say that no drug intervention trial was able to demonstrate a benefit that would justify the wide spread use of the drug in NAFLD/NASH[45-47]. We are not aware of solid data on the effects on post liver transplant outcomes of treatment of insulin-resistance prior to liver transplantation in patients with NAFLD. Thus, beyond life style measures and the control of risk factors[48], there is currently no universally accepted medical therapy with proven efficacy available for NAFLD/NASH. Dietary modifications could affect the progression of NAFLD. In a recent study, Kontogianni *et al*[49] found that patients with NAFLD adhering to a Mediterranean diet had less severe liver disease and lower degree of IR[49]. Additionally, the role of bariatric surgery at time of LT in patients with obesity and NASH related cirrhosis remains to be defined[50].

**CONCLUSION**

NAFLD is expected to become the most common indication for liver transplantation within the next 1-2 decades. Despite the fact that recent studies have shed some light on the prevalence of NAFLD in patients awaiting LT and on the outcomes of recipients transplanted for NASH related cirrhosis, many aspects remain ill defined. The latter include, but are not limited to, the proportion of patients with NASH cirrhosis that is a priori excluded from liver transplantation because of co-morbidities, as well as strategies allowing to prevent the increased CV and infection related morbidity and mortality in recipients transplanted for NASH. The latter include bariatric surgery at the time of LT and attempt to tailor immunosuppressive regimens to the risk factor profile in NASH recipients. To address these and other issues, adequately powered, prospective, and whenever possible controlled trials will be required.

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**Figure 1 Natural history of the nonalcoholic fatty liver disease.** NAFL: Nonalcoholic fatty liver; NASH: Nonalcoholic steatohepatitis; HCC: Hepatocellular carcinoma; NAFLD: Nonalcoholic fatty liver disease.



**Figure 2 Impact of nonalcoholic fatty liver disease/nonalcoholic steatohepatitis on liver transplantation.** LT: Liver transplantation; NASH: Nonalcoholic steatohepatitis; HCC: Hepatocellular carcinoma; NAFLD: Nonalcoholic fatty liver disease.

**Table 1** **Nonalcoholic steatohepatitis related cirrhosis as an indication for liver tranplantation.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **References** | **Database** | **Years** | **NASH Cirrhosis Tx** | **NASH Cirrhosis waiting list** |
| Charlton *et al*[9] | SRTR | 2001-2009 | Increased  1.2% 🡪 9.7% |  |
| Kemmer *et al*[10] | UNOS | 2007-2010 | Increased  5.1% 🡪7.5% |  |
| http://optn.transplant.hrsa.gov | OTPN | 2013 Nov 1st |  | 8.5%  +5.5% for CC |

NASH: Nonalcoholic steatohepatitis; CC: Cryptogenic cirrhosis; Tx: Transplantation; SRTR: Scientific registry of transplant recipients, United States; UNOS: United network for organ sharing, United States; OTPN: Organ procurement and transplantation network, United States.

**Table 2 Post liver transplantation outcomes for nonalcoholic fatty liver disease, nonalcoholic steatohepatitis**

|  |  |  |  |
| --- | --- | --- | --- |
| **Reference** | **NASH** | **Non-NASH** | **Remarks** |
|  | **Post-LT mortality** | |  |
| Malik *et al*[26]  24 h  30-d  1-yr  3-yr  5-yr | 4%  6%  21.5%  25.5%  27.5% | 1-3%  2-5%  13-18%  16-30%  19-35% | Non-NASH: PBC, PSC, ALD, HCV  NASH group: Increased early mortality  Infection: Main cause of death in NASH group (50%)  High risk NASH group: 50% 1-yr mortality  Older age (> 60 yr),  Higher BMI (> 30 kg/m2),  Pre-LT diabetes mellitus and  Hypertension |
|  | **Post-LT survival** | |  |
| Bhagat *el al*[27]  1-yr  3-yr  5-yr  9-yr | 82%  79%  75%  62% | 92%  86%  86%  76% | Non-NASH: ETOH  NASH group  Higher cardiovascular morbidity  Higher risk of acute rejection and  recurrent steatohepatitis |
| Barrit *et al*[28]  30-d  1-yr  3-yr | 81%  76%  76% | 97%  89.5%  83.5% | NASH group: Increased early mortality  All recipients: Diabetes, risk factor for increased 3-yr mortality |
| Afzali *et al*[29]  1-yr  3-yr  5-yr | 87.6%  82.2%  76.7% | Variable | Non-NASH: Any other indication  NASH group: Excellent survival, similar to PSC and HBV |
| Singal *et al*[30]  1-yr  3-yr  5-yr  10-yr | 89%  85.5%  84%  84% | Variable | Non-NASH: PSC, PBC, ALD, HCV, HVB, CC, HCC  NASH group: Excellent survival, 3-, 5-yr survival best of all |

Post-LT: Post liver transplantation; NAFLD: Nonalcoholic fatty liver disease; NASH: Nonalcoholic steatohepatitis; PSC: Primary sclerosing cholangitis; PBC: Primary biliary cirrhosis; ALD: Alcoholic liver disease (ETOH); HCV: Hepatitis C virus; HVB: Hepatotis B virus; CC: Cryptogenic cirrhosis; HCC: Hepatocellular carcinoma.