I was asked to write local guidelines for our referral management service for GPs to manage asymptomatic abnormal liver function tests (LFTs). ‘I’d be delighted’, I said. ‘How hard can it be?’ I thought.

I was only a year off being a consultant in gastroenterology (including having worked at King’s Liver Unit) when I changed to general practice. That was 10 years ago. Now half my week is as a salaried GP, and I spend the other half performing endoscopy at our district general hospital and I have close ties to the gastro department. I’ve got an understanding of the liver and primary care, and secondary care and the referral system. Let’s crack on.

PREVALENCE OF LIVER DISEASE

We know liver disease is a problem and it is only increasing in the UK, predominantly from an increase in alcohol-related liver disease, non-alcoholic fatty liver disease (NAFLD), and hepatitis C virus (HCV). Whereas other causes of death are dropping, liver deaths are the third commonest cause of premature death in the UK and rates are rising. Where other causes of death have fallen, from an increase in alcohol-related liver disease, non-alcoholic fatty liver disease (NAFLD), and hepatitis C virus (HCV). Whereas other causes of death are falling (NAFLD), and hepatitis C virus (HCV). Whereas other causes of death are falling, other causes of death are dropping, liver deaths are the third commonest cause of premature death in the UK and rates are rising. Where other causes of death have fallen, from an increase in alcohol-related liver disease, non-alcoholic fatty liver disease (NAFLD), and hepatitis C virus (HCV). Whereas other causes of death are falling (NAFLD), and hepatitis C virus (HCV). Whereas other causes of death are falling, liver deaths are the third commonest cause of premature death in the UK and rates are rising. Where other causes of death have fallen, from an increase in alcohol-related liver disease, non-alcoholic fatty liver disease (NAFLD), and hepatitis C virus (HCV).

Up to one-third of the UK adult population have NAFLD and 2–3% have more advanced fibrotic disease: non-alcoholic steatohepatitis (NASH). Those with NAFLD are younger than in cardiopulmonary disease. Whereas other causes of death are dropping, liver deaths are the third commonest cause of premature death in the UK and rates are rising. Where other causes of death have fallen, from an increase in alcohol-related liver disease, non-alcoholic fatty liver disease (NAFLD), and hepatitis C virus (HCV). Whereas other causes of death are falling (NAFLD), and hepatitis C virus (HCV).

Fibrosis2 and that’s not far off the 3% positive predictive value bar set by the National Institute for Health and Care Excellence (NICE) for new urgent suspected cancer referrals. We often refer patients with a much lower than 2% risk of significant disease. I explained that we don’t know the numbers needed to screen or survey to prevent decompensation or death. The evidence is meagre and of low quality in NICE’s draft full guidance on cirrhosis but this is what the specialist societies advise.

‘We’re not publishing these guidelines’, I was told emphatically. I realised I had this scenario well from my interest in overdiagnosis. As generalists we know the yield of investigating ‘pre-disease’ is very small, the vast majority of patients won’t benefit and some will be harmed. But as specialists, day after day we live in the tip of the iceberg, which is sick, yellow, and sometimes dead and we want to make things better. As the middleman I couldn’t get the generalist and specialist agendas to overlap.

In the future, with increased availability of fibroscanners, more creative service design, and integrated working [plus time, money, and effort] we could assess patients locally and get those at highest risk into the hepatology services as dreamed about in the latest draft NICE guidelines on cirrhosis.3 But for the moment, we’re stuck.

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