

have directly compared these two compounds vs. cyanocobalamin for stroke prevention in individuals with normal and/or impaired renal function. Moreover, the relative efficacy of these B12 compounds and the generation of toxic metabolites in the context of liver disease has not been examined. Interestingly, Talari *et al.* recently treated individuals with NASH with 1,000 ug cyanocobalamin for 12 weeks in a randomized control trial and observed statistically significant decreases in serum homocysteine and alanine aminotransferase, and hepatic steatosis after treatment in the treatment group, but found no significant changes when compared to the placebo group.⁹ Although this study suggested there might be beneficial results with cyanocobalamin, it is not clear whether the findings would have been more robust if patients were treated with either methylcobalamin or hydroxycobalamin. Thus, while it appears that cyanocobalamin may confound the assessment of stroke prevention in patients with renal failure, it is not known whether this is the case for NASH without direct comparisons or further study of the B12 compounds. However, Dr. Spence's caution on the use of particular B12 compounds in individuals with NASH is reasonable and needs to be considered, particularly if patients have concomitant renal impairment. Thus, in the absence of definitive data in individuals with NASH and renal failure, it

still may be prudent to use methylcobalamin or hydroxycobalamin rather than cyanocobalamin for the treatment or prevention of NASH in clinical studies.

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MT, BKS and PMY finalized the letter.

Supplementary data

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Depiction of alcohol-related liver disease in the EASL International Liver Congress

To the Editor:

In some clinical or social interactions, the term “alcoholic” is a pejorative or stigmatising label applied to people with an

alcohol use disorder (AUD).¹ When alcohol is consumed in quantities considered excessive or potentially harmful, it risks precipitating or perpetuating adverse physical and mental

health outcomes. However, labelling individuals with patterns of excessive alcohol intake as “alcoholic” fails to reflect the complexities of the genetic and biopsychosocial factors that lead to addiction, while defining people by their illness. In a recent edition of *Journal of Hepatology*, Schomerus and colleagues reviewed the stigma of alcohol-related liver disease.² They noted that concerns about stigma related to disclosure of alcohol use not only discourages and delays health-seeking behaviour by individuals with harmful alcohol use, but also risks provision of sub-standard healthcare and potentially worse health outcomes for an already underserved population who are sometimes regarded as undeserving of equal health and healthcare compared with their peers.²

While the role of alcohol in development and progression of fatty liver and liver-related outcomes had been detailed as far back as the early nineteenth century,³ alcohol and other lifestyle factors at that time were described in somewhat disparaging terms. The European Association for the Study of the Liver (EASL) Clinical Practice Guidelines published in 2018 tackled the nosology of alcohol-related liver disease, and encouraged more progressive and less stigmatising diagnostic labels that avoid the term “alcoholic” that was felt to undermine patient self-esteem and dignity.⁴ Importantly, the term “alcohol-related liver disease” was preferred over “alcoholic liver disease”, as it recognises alcohol as a contributing factor in liver disease and hopefully reduces anchoring bias. Surprisingly, the EASL guidelines retained the term “alcoholic hepatitis” for now. The American Association for the Study of Liver Diseases (AASLD) Practice Guidance similarly recommends a change from use of “alcoholic” to “alcohol-associated” liver diseases.⁵

In light of the progress in understanding of addictions, socio-demographic factors related to AUD, and stigma directed towards alcohol-related liver disease,² we examined the depiction of alcohol-related liver disease in abstracts and session names at the recently concluded EASL International Liver Congress 2022. We found “alcoholic liver disease” was a subcategory for abstract presentations, comprising forty-seven abstracts.⁶ After excluding six abstracts about “alcoholic hepatitis”, twelve of the remainder (29.3%) referred to “alcoholic liver disease”, “alcoholic steatohepatitis” or “alcoholism” rather than the recommended nomenclature outlined by the EASL Clinical Practice Guideline. Amongst twenty-one abstracts referring to alcohol-related hepatitis, 13 (61.9%) referred to the condition as “alcoholic hepatitis”. This demonstrates that over one-third of clinicians/scientists who submitted abstracts regarding “alcoholic hepatitis” took the initiative of calling it alcohol-related hepatitis.

Whilst it may be argued that simple terminology will have a minor impact on patient outcomes, it could reflect an easily overcome barrier to better healthcare in an already vulnerable population. Fear that admission of heavy alcohol use would result in stigma from clinicians, and attempts by non-drinkers to distance the aetiology of their liver disease from perceptions of

an alcohol aetiology, hence “alcoholic”, may result in defensiveness, shame, guilt and avoidance of discussions around alcohol intake.^{7,8} The fear of being labelled as an “alcoholic” has been linked to patients avoiding appropriate treatment.⁸ Additionally, the use of stigmatising language leads to reduced problem recognition, and the perception of being labelled an “alcoholic” shames patients into understating the severity of their alcohol intake.² Potentially, people may then remain in the pre-contemplative stage of harm reduction and avoid making meaningful improvements to their lifestyle. It is well understood that the best way to improve health outcomes within alcohol-related diseases is to focus on harm reduction, such as a decreased intake, or controlled progression to abstinence; any small changes may help.

Although the International Classification of Diseases 11th Revision (ICD-11)⁹ is yet to update the diagnostic label “alcoholic”, there is a push for a change in nomenclature in ICD-12 liver disease coding that would recognise the contribution of alcohol to the burden of liver disease but remove stigmatising terms, such as “alcoholic”.¹⁰ This would encourage widespread adoption of contemporary descriptors amongst clinicians and researchers.

In conclusion, despite the EASL and AASLD recommendations for updating terminology in alcohol-related liver disease, the 2022 International Liver Congress abstracts have shown that uptake of progressive nomenclature is limited amongst the hepatology community. It is concerning to see that over one-quarter of abstracts still used the historical stigmatising terminology. Conferences with world-leading hepatologists have a global reach, and therefore the opportunity to accelerate global change. Changing the section title to alcohol-related or alcohol-associated liver disease in future conferences, plus encouraging abstract submissions to use these would provide leadership in this subject. If EASL leads, the world will follow.

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Authors' contributions

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Supplementary data

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Reply to: “Depiction of alcohol-related liver disease in the EASL International Liver Congress”

To the Editor:

We thank Dr Goodheart and Dr Ayonrinde for their assessment of the implementation rate of the new nomenclature for alcohol-related liver disease proposed by EASL in the Clinical Practice Guideline from 2018,^{1,2} as part of the alcohol-related presentations at the EASL 2022 International Liver Congress in London. They showed that the new terminology has not yet been fully adopted in the community and that the former nomenclature continues to be used even at EASL events. Further, the proposed changes have not been adopted by the WHO and not implemented in the International Classification of Diseases (ICD)-11 2022 update.

As the authors correctly point out, EASL acknowledges that the term “alcoholic” is stigmatizing, often does not reflect the complex aetiology of alcohol-related liver disease, and should therefore be avoided in order to not only maintain patient’s dignity and self-esteem, but also to improve personalised care. Yet, the abstract categories at the congress did not reflect this progress and neither did some of the abstract contributions from the field. We thank the authors for pointing this out and bringing this to our attention. The recent EASL-Lancet commission further unfolded the nature of stigma and discrimination and the severe consequences to patients with liver diseases.³ Fighting stigma and stigmatizing language of liver diseases is a priority to the EASL Governing Board. It is a clear goal of EASL to implement the more progressive terminology in all EASL events and publications.

From an EASL perspective, the nomenclature should reflect that in many cases the consumption of alcoholic beverages constitutes a co-factor and not the sole cause of chronic liver disease. This should also stimulate the initiation of studies to better understand genetic, environmental, and other individual factors that contribute to the progression of the disease and thereby improve education and prevention measures.

The authors also mention the fact that EASL guidelines suggest to maintain the term alcoholic hepatitis for now. While the term appeared “too standardized to change” by the expert panel during the development of the guideline, they already state that this term “may be reviewed in future guidelines” and the term “alcohol-related acute liver injury” is suggested by the EASL-Lancet commission.²

To further stimulate the implementation of the proposed new nomenclature for alcohol-related liver diseases, we have now amended the title of the abstract category for the EASL Congress 2023 in Vienna, which is now “Alcohol-related liver diseases”. In addition, we will modify the authors’ guide for abstract submission to include a paragraph that encourages the use of the most appropriate language, specifically emphasizing that the term alcoholic liver disease should not be used anymore. We will also instruct our abstract reviewer to flag all abstracts that are not adhering to these recommendations so that we can specifically contact the respective authors to modify their submission accordingly.