Comments on the "WGO Guidance for the Care of Patients With COVID-19 and Liver Disease"

To the Editor:

We read with great interest the article by Hamid et al[1] about the World Gastroenterology Organization (WGO) guidance for the care of patients with coronavirus disease 2019 (COVID-19) and liver disease. However, we would like to point out some issues in this article.

First, in the table 1 entitled as "A Step-wise Approach in COVID-19 Patients Suspected to Have Hepatobiliary Disease," the authors firstly aimed to determine the cause(s) of liver jury in COVID-19 infection.[1] Of note, according to the format of this table, "COVID-19 infection per se" should include "Complication of COVID-19." "Pre-existing liver disease," and "Concomitant medical problems." In other words, the latter three causes seem to fell under the category of "COVID-19 direct infection per se." However, direct virus infection should be juxtaposed with complication of COVID-19 as the potential causes of liver injury in COVID-19 patients.[2,3] Therefore, the organization of table 1 should be improved to avoid the readers' misunderstandings.

Second, in the table 4 entitled as "WGO Recommendations for Patients With Chronic Hepatitis B and C in the Era of COVID-19," the authors said "Treat those diagnosed with HBV or HCV with DAAs."[1] However, according to the current management guidelines for hepatitis B virus (HBV),[4] the main treatment options of HBV infection are pegylated interferon-α or nucleoside analogues at present, despite several direct-acting approaches are being developed. Moreover, the role of new direct antiviral medications for HBV is different from that for hepatitis C virus (HCV).[4] Whether HBV can be treated with direct acting antiviral (DAAs) still deserves further studies. Therefore, such words regarding treatment of DAAs for HBV in the table 4 should be redefined.

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Statins and Cancer Mortality in NAFLD

Is it Too Early to Rejoice?

To the Editor:

We read with interest the article by Hajifathalian et al,[1] wherein they reported that statin use is associated with a decrease in cancer-related mortality among patients with non alcoholic fatty liver disease (NAFLD).

However, this article raises a few deserving concerns. To begin with, the study does not mention the exact number of statin users among the baseline (n = 986) cancer patients during enrollment. Next, as per the study, the total statin users were 2523 and among these patients, 1655 patients had low fibrosis risk and 717 patients had high fibrosis risk. Fibrosis scores were missing in 151 statin users and a valid explanation for the same was amiss. Also, the anticancer effect of statin is both time and dose dependent,[2] and this study fails to mention the dose at which different statins were prescribed. Besides, as use of Metformin in diabetics is associated with reduced risk[3] of hepatocellular carcinoma, we would also like to know the number of diabetic patients on statins who were also on metformin. Furthermore, chronic kidney disease, which is independently associated with increased overall mortality[4] in patients with NAFLD, has not been considered as a competing risk for cancer mortality in this study. Moreover, survival benefit of drugs like beta blockers[5] in patients with cardiovascular disease has not been taken into account in this study, and this may well be an unadjusted confounding factor. Finally, "other causes" of death in NAFLD patients in this study is surprisingly more than the combined cardiovascular disease and cancer-related deaths, which makes the results very ambiguous.

In the light of the aforementioned reasons, more studies are required to evaluate the protective role of statins in cancer mortality in patients with NAFLD to make the article more conclusive.

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