Addressing transplant inequity for patients with alcohol abuse disorder in Mexico – The elephant in the room

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Upon an etiologic transition of cirrhosis in Mexico and globally, alcoholic abuse disorder (AAD) remains unwavering as the first or second cause of liver disease, depending on the region analyzed. As established by Chagolla-González, around 24% of cases of cirrhosis are secondary to alcohol abuse.[1] Nonetheless, liver transplant in these patients remains concerningly low. In Mexico's largest transplant centre,[2] less than 10% of transplants were performed on patients with alcoholic cirrhosis.[3] Albeit referral bias is present, transplant is curative in end-stage liver disease, and referral should happen independently of aetiology.

Scant referral of cirrhosis due to AAD raises concern for physician and patient miseducation and stigma. Firstly, referring physicians might suppose that a six-month period of abstinence is required for a transplant. Secondly, fear of recurrence from inadequate psychosocial support and a tenuous trust in a patient's abstinence after transplant might veer against their referral to a transplant centre. Thirdly, and most importantly, frank prejudice on behalf of referring physicians might hinder prompt referral, due to an unjustified belief that some patients are "more deserving" than others. Furthermore, the patients' and their families' own perception of alcoholic cirrhosis might delay seeking help. Notably, AAD is frequently associated with other psychiatric comorbidities, which might make these patients feel undeserving of a transplant. This is painfully reminiscent of general psychiatric illness where patients can also fail to seek attention opportunely.

The role of transplants in alcoholic liver disease could potentially be misconstrued. Former paradigms requiring an arbitrary six-month abstinence period, which does not improve mortality or abstinence after transplant,[4] have been disproven. Moreover, current practice establishes that an abstinence trial is unwarranted,[5] particularly upon severe alcoholic hepatitis. Liver transplant in alcoholic cirrhosis holds promise, as, unlike other diseases, a complete cessation of hepatic injury can be achieved with abstinence. Thus, we firmly believe this represents an area of opportunity for better care.

Mexican healthcare clearly has room for improvement, and untimely and inadequate referral of patients with alcoholic cirrhosis must be addressed through nationwide changes. Physician education must emphasize AAD, and arbitrary six-month abstinence periods should be halted. Additionally, strengthening addiction medicine and rehabilitation programs could enable a referring physician's trust. Finally, standardization of referral policies must be undertaken to facilitate care at an appropriate level of attention. Liver transplant for alcoholic cirrhosis continues to challenge Mexican healthcare, but to turn it into an opportunity, we must first acknowledge the elephant in the room.

Contributors

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Declaration of interests

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