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# Comment on "Integrating an addiction team into the management of patients transplanted for alcohol-associated liver disease reduces the risk of severe relapse"

*To the Editor:*

The scholarly work by Jules Daniel *et al.*,[1] was both enlightening and commendable in its quest for knowledge. We wholeheartedly support the authors' ultimate conclusion, highlighting the advantages of incorporating an addiction team to curb alcohol relapse post-liver transplant. Nevertheless, we are eager to contribute additional insights to enhance the study's discoveries.

The article relies on self-reported patient responses and statements from patients without conducting blood or urine tests, potentially compromising data reliability due to social desirability bias or inaccuracies. Conversely, another study by Carrique *et al.*[2] employs ethyl glucuronide urine testing, an objective measure that enhances data credibility by verifying alcohol use. This approach stands out for its rigorous and scientifically sound assessment of alcohol consumption in patients with alcohol-related liver disease (ALD), strengthening its conclusions on addiction treatment and relapse rates.[2,3]

Another point of contention lies in the adequacy of the traditional 6-month abstinence rule in predicting survival and relapse rates among patients with ALD. The study by Carrique *et al.*[2] emphasizes the growing consensus that this rule may need to be revised to make informed decisions about transplantation eligibility. Moreover, it argues for the need to reassess and possibly revise this criterion to ensure equitable access to transplantation for patients with ALD.

The critical perspective offered by the study suggests a departure from the conventional approach. It advocates for the incorporation of specialized psychosocial criteria to assess the risk of future relapse in patients with ALD, irrespective of their length of abstinence. This approach represents a fundamental shift in how transplantation eligibility is determined for this patient population.[4]

The article has not implemented exclusion criteria for patients with a significant psychological history. It is well established that individuals with a significant psychological history are more susceptible to sudden and severe alcohol relapse, potentially introducing bias into the collected data. While the authors of this research have acknowledged inquiring about patients' co-morbidities, it is imperative to note that a more comprehensive approach should have been taken. Specifically, the investigation should have encompassed whether patients suffering from these co-morbidities were receiving specific medications and whether they were in compliance with their prescribed regimens. Neglecting this aspect could lead to an incomplete understanding of the potential impacts of unmanaged co-morbidities on liver disease and overall patient health.

An apparent limitation in the study design is the inclusion of patients suffering from severe symptoms before transplantation who were not assessed during the pre-transplantation process. This approach introduces the potential for data bias. To address this concern, either these individuals should have been excluded from the study or, alternatively, a distinct study should have been conducted to examine their specific post-transplantation outcomes. Failure to address this issue may compromise the integrity of the findings.[5]

We believe that these considerations will contribute to a more comprehensive and nuanced understanding of the subject matter, enhancing the overall quality and impact of the research.

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## Conflict of interest

The authors of this study declare that they do not have any conflict of interest.

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## Authors' contribution

Nayab Shahid: Concept and Idea, Article Search, Literature Review, and Manuscript Writing. Muhammad Aizaz Ur Rehman: Article Search, Literature Review, and Manuscript Writing.

## Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.jhepr.2023.100938.

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