6. Priority diseases and reasons for inclusion

6.14 Alcohol use disorders and alcoholic liver disease

See Background Paper 6.14 (BP6_14Alcohol.pdf)

Background

The WHO estimates that alcohol is now the third highest risk factor for premature mortality, disability and loss of health worldwide.\(^1\) Between 2004 to 2006, alcohol use accounted for about 3.8% of all deaths (2.5 million) and about 4.5% (69.4 million) of Disability Adjusted Life Years (DALYS).\(^2\) Europe is the largest consumer of alcohol in the world and alcohol consumption in this region emerges as the third leading risk factor for disease and mortality.\(^3\) In European countries in 2004, an estimated one in seven male deaths (95 000) and one in 13 female deaths (over 25 000) in the 15 to 64 age group were due to alcohol-related causes.\(^3\)

Alcohol is a causal factor in 60 types of diseases and injuries and a contributing factor in 200 others, and accounts for 20% to 50% of the prevalence of cirrhosis of the liver. Alcohol Use Disorders (AUD) account for a major part of neuropsychiatric disorders and contribute substantially to the global burden of disease. Alcohol dependence accounts for 71% of all alcohol-related deaths and for about 60% of social costs attributable to alcohol.\(^4\) The acute effects of alcohol consumption on the risk of both unintentional and intentional injuries also have a sizeable impact on the global burden of disease.\(^2\)

Alcoholic liver disease (ALD) is the commonest cause of cirrhosis in the western world, and is currently one of the ten most common causes of death.\(^5\) Liver fibrosis caused by alcohol abuse and its end stage, cirrhosis, present enormous problems for health care worldwide. Over 60% of patients with cirrhosis of the liver and superimposed alcoholic hepatitis have a life expectancy of only four years. Overall, stopping drinking has been shown to improve the survival of patients with all stages of ALD.

Developments since 2004

Despite the high global burden of alcohol-related diseases and injuries, alcohol use remains a low priority for public health policy. In North America, only an estimated 14.6% of people with a lifetime history of alcohol abuse or dependence have received treatment.\(^6\) In Europe, only an estimated 8% of people with alcohol dependence receive treatment.\(^7\) These low figures demonstrate that there are many barriers to treatment.

Several policy options have been tested to reduce alcohol consumption, including: drunk driving reduction; education, communication, training and public awareness; alcohol market regulation; reduction of harm in drinking and surrounding environments; and interventions for individuals.
The currently approved pharmacotherapeutical options for AUD are disulfiram, naltrexone, and acamprosate. Other drugs are being investigated, used off-label (topiramate and ondansetron) or recently approved in Europe (nalmefene) for use in patients with alcohol dependence who want to reduce their alcohol consumption, either as a treatment goal or as a step towards abstinence. While some of these drugs have shown promise in terms of efficacy (nalmefene, topiramate, and ondansetron), none has been found to be effective when used as a single treatment method, without some form of concurrent behavioural therapy.

Coexisting diseases (especially mental disorders, but also noncommunicable diseases (NCDs) such as cardiovascular disease, cancer, diabetes or liver disorders) are highly prevalent among people suffering from AUD. The most recent evidence supports a change from the current practice of treating both diseases (mental disorders and alcohol dependence) separately, to a new approach of incentivizing better coordination between clinics and centres to treat addictions. However, effective scaling up of services with improved coordination between health care for AUD and other NCDs has been challenging.

In the United States, there are no therapies for ALD which have been approved by the U.S. Food and Drug Administration (FDA). Although many treatment methods have been tried in patients with alcoholic hepatitis, few of them have been consistently shown to have a beneficial effect and none has achieved consensus status among practising hepatologists. As a result current therapy still focuses predominantly on supportive care.

**Research needs**

Although an increase in funding related to alcohol and health has been reported over the last year in the EU, the level of funding seems insufficient in view of the enormous economic and social burden of ALD on the health care system.

More evidence is needed to determine the effectiveness of many of the interventions to reduce harmful alcohol consumption. In addition, health system research is needed to identify appropriate organizational models to effectively coordinate treatment for AUD and other NCDs and to scale these up.

With respect to pharmacotherapy, the development of suitable medications with greater selectivity toward excessive alcohol intake remains a major research goal. Efforts to understand the neurobiological basis and their corresponding effects of the pharmacotherapeutic interventions in individuals with AUD, potentially through the use of new imaging technologies, provides relevant avenues for future research.

Current treatments for alcohol-related cirrhosis of the liver are severely limited. Better understanding is needed in relation to: the pathogenesis of the disease; helping patients to abstain from alcohol (where possible); eradicating existing viruses using interferon, ribavirin, and lamivudine (in cases involving viral hepatitis); liver
transplantation;¹² and developing adjunctive pharmacotherapies that can improve survival rates.¹²

References


