The future of therapy for alcoholic hepatitis - beyond corticosteroids

Keywords: alcoholic hepatitis; bile acids; hepatocyte injury; hepatocyte repair; nutrition; nosocomial infection; hepatorenal syndrome; portal translocation of gut microbiota

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RESTORE MUSCLE MASS
NUTRITIONAL SUPPLEMENTS
ORAL FEEDING
NASOGASTRIC TUBE FEEDING

Canakinumab
Anti-LPS IgG
Bovine Colostrum

Zinc, OCA
Faecal Microbiota Transplantation
Probiotics
Rifaximin

Canakinumab
Anakinra

Portal Translocation of Gut Microbiota

Complications of Alcoholic Hepatitis

Defective Immune Cells
- ↑ IL-10, ↓ IFNγ secretion
- Defective phagocytosis
- Depleted defective MAIT cells
- Expression of monocye HLA-DR
- Therapy associated defects

NAC, G-CSF

Neutrophil
- Elevated neutrophil resting burst
- Endotoxin sensitivity
- Activated MAIT cells

Primed Immune Cells
- ↓ NO production
- ↑ ROS production
- Inflammatory cytokines

Enterocyte
- Enterocyte
- Enterochromaffin cells

Enterocyte
- Enteroendocrine cell
- Enterochromaffin cells

Liver
- Hepatocyte
- Cholangiocyte
- Ductular cell

Keywords:
- Hepatocyte damage
- Cholangiocyte damage
- Ductular cell damage
- Enteroendocrine cell damage

Hepatology Snapshot:
The future of therapy for alcoholic hepatitis - beyond corticosteroids

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Corticosteroids are the only treatment proven to reduce mortality from severe alcoholic hepatitis (SAH), though the benefit is short-lived. Several potential therapies are currently under evaluation in human clinical trials (Table 1). These therapies target: i) malnutrition; ii) intestinal dysbiosis and its portal translocation; iii) bile acid production; iv) hepatocyte death; v) hepatocyte regeneration; and vi) life-threatening complications of the disease itself.

Nutritional supplements
Malnutrition is common in this group of patients. Good nutrition is a central tenet of SAH management. Intensive nutrition delivered enterally or parenterally does not appear to confer clinical benefit. However, achieving a calorific intake >21.5 kcal/kg per day is associated with a reduction in complications and mortality.

Portal translocation of gut microbiota
Intestinal dysbiosis has been implicated in a range of hepatic diseases. Alcohol consumption causes intestinal dysbiosis and impaired intestinal barrier function. Transfer of intestinal microbiota from humans with SAH to mice confers susceptibility to alcohol-induced steatohepatitis, which can be reversed by faecal microbiota transplantation from humans who drink heavily but do not develop SAH.

Current trials aim to improve bacterial dysbiosis using i) orally administered non-absorbable antibiotics (rifaximin or combined gentamicin, vancomycin and meropenem); ii) probiotics (Lactobacillus rhamnosus [NCT01922889] and acidophilus [NCT02335632]); or iii) faecal microbiota transplantation.

Enterohepatic circulation of bile acids
SAH is characterised by marked biochemical and histological cholestasis. The farnesoid receptor (FXR) is a key regulator of bile acid synthesis. Receptor agonism also improves gut barrier function in mouse models of alcohol-related liver disease. Additional beneficial effects from FXR agonism in ameliorating portal hypertension have been suggested in rodent models of liver disease (reviewed in ). Obeticholic acid (OCA) is a semi-synthetic agonist of FXR that has shown promise in non-alcoholic fatty liver disease and has established efficacy in primary biliary cholangitis. Clinical trial data are awaited (NCT02039219).

Immune dysfunction
Immunotherapy for SAH is challenging because hepatic immunopathology exists concurrently with systemic immune defects. Accordingly, attempts to control hepatic

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Table 1. Active published clinical trials for alcoholic hepatitis listed by the U.S. National Library of Medicine at clinicaltrials.gov and European Clinical Trials Database at EudraCT.
immunopathology with systemic immunosuppressants, such as anti-TNFα or corticosteroid therapy, are hampered by high rates of infection that offsets clinical benefit. Pre-clinical data suggest that anti-IL-1β therapy does not confer such susceptibility to opportunistic infection and reduces hepatic inflammation, fibrogenesis, stellate cell activation and consequent portal hypertension (NCT02655510, NCT01903798, NCT01809132, EudraCT 2017-003724-79, NCT03775109).

Hepatocellular injury and repair
Ethanol metabolism and immune responses lead to the generation of reactive oxygen species (ROS) that cause oxidative stress and hepatocellular damage. In single studies, the combination of intravenous N-acetylcysteine10 or oral metadoxine11 with corticosteroids appears to confer a survival benefit and is the subject of ongoing investigation (N-acetylcysteine [NCT03069300]; metadoxine [NCT02019056, NCT02161563]) along with S-adenosyl-L-methionine (SAME) [NCT00851981, NCT02024295]. The efficacy of G-CSF, in part mediated via hepatic regeneration,12 has been suggested by small studies13 and several trials are in progress aiming to replicate these findings. Similarly, IL-22 has been ascribed hepatoprotective and pro-regenerative features; therapeutic agents are under clinical evaluation (NCT02655510).

Extrahepatic complications of alcoholic hepatitis
Infection: up to 50% of SAH patients will develop infection during the acute illness and nosocomial infections reduce survival.14 Defective immune cells have been identified in the systemic circulation of patients with SAH and their presence is associated with the development of infection.15–18 Reversing these defects (NCT03069300) or predicting infections are attractive prospects. An alternative approach is to treat all SAH patients with broad-spectrum adjunctive antimicrobial therapy such as co-amoxiclav (NCT02281929) and ciprofloxacin (NCT02326103) and these two agents are currently under evaluation.

Acute kidney injury: kidney injury that occurs with SAH portends a poor prognosis. Primed immune cells release a plethora of inflammatory mediators, in particular ROS and nitric oxide, which cause vasodilatation in the splanchnic circulation. The vasopressin analogue terlipressin reduces this vasodilatation and is under investigation for SAH specifically.

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Conflicts of interest
MT reports grants and personal fees from Gilead and CN_BIO; personal fees from AbbVie and MSD; grants from Vital Therapeutics. All other authors report no conflict of interest.

Please refer to the accompanying ICMJE disclosure forms for further details.

Supplementary data
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References
Author names in bold designate shared co-first authorship


