**Evidence table**

**TRANSP: What length of abstinence is needed to establish non-recovery of liver damage, which thereby necessitates referral for consideration for assessment for liver transplant?**

<table>
<thead>
<tr>
<th>Ref ID: 300</th>
<th>Study type/ Evidence level</th>
<th>Number of patients</th>
<th>Patient characteristics</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Length of follow-up</th>
<th>Outcome measures</th>
<th>Source of funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veldt BJ, Laine F, Guillygomarc'h A et al. Indication of liver transplantation in severe alcoholic liver cirrhosis: quantitative evaluation and optimal timing. <em>Journal of Hepatology</em>. 2002; 36(1):93-98.</td>
<td>Retrospective/ prospective case series 3</td>
<td>Liver division of an academic hospital in western France during 1997; tertiary care centre (inpatients + outpatients)</td>
<td><strong>Inclusion criteria:</strong> Patients that required admission to hospital for complications of a first episode of Child C cirrhosis of alcoholic origin (i.e. alcohol consumption &gt;3 units a day for males or &gt;2 units a day for females, for more than 5 years). Diagnosis of cirrhosis relied on classical clinical, biological and imaging criteria and on liver histology when available (n=11)</td>
<td>Abstinence</td>
<td>N/A</td>
<td>4 yrs</td>
<td>Survival and transplantation Prognostic factors Improvement of liver function (Child-Pugh score improvement from C to B or A)</td>
<td>SOCRATES grant from the European Union; grants from the Association pour la Recherche contre le Cancer and the Association Fer et Foie.</td>
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<td>N= 74 N=19 at follow up (via questionnaire to patients’ GPs)</td>
<td><strong>Exclusion criteria:</strong> patients with all other cause of cirrhosis (including hepatitis and haemochromatosis), referral for pre-transplant evaluation from another team or a</td>
<td>Patients were considered as abstinent when they declared to be so and evolution of biological markers was in accordance. Patients who decreased their consumption to a non-excessive level (&lt; 3 units per day for a man, 2 units per day for a woman) with normalization of GGT and MCV were considered sober.</td>
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<td>previous episode of Child C cirrhosis, before 1997.</td>
<td>Alcohol consumption during follow up was assessed by self-reported alcohol consumption, biological markers (alcohol blood level, evolution of GGT and MCV) and appreciation of the general practitioner in charge.</td>
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**Patient characteristics:**
- Sex: female 27, male 47;
- Age (years) 59 (37-82);
- Child Pugh score 11 (10-15);
- Ascites: none 12, mild 30, tense 28, refractory 2;
- Encephalopathy: none 45, asterixis 14, confusion or coma 12;
- Alcohol consumption during follow up (%): none 12 (21), sober 2 (5), relapse 19 (31), excessive 9 (21), unknown 13 (22).

**Effect Size**

**Outcomes**

**Improvement of liver function:**
- The rate of liver improvement in abstinent patients:
  - 1 month: 23%
  - 2 months: 40%
  - 3 months: 66%
  - 6 months: 66%
- Improvement in Child-Pugh score always began within 3 months if it occurred.
- In 15 relapsing patients, initial abstinence resulted in liver function improvement.
- 1 liver transplant was performed for persisting liver failure despite abstinence (1.3%, 95% CI 0.0-3.9)
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- Most of the abstinent patients improved their liver function up to a Child-Pugh score of A, so that liver transplantation was no longer indicated.
- Of the 74 included patients only one was ultimately suitable for transplantation.

Authors Conclusion:
- Liver transplant should be considered when improvement in liver function is lacking (Child-Pugh score remains at C) after 3 months of abstinence.