LETTER TO THE EDITOR

Alcohol and liver transplantation: the 6-month abstinence rule is not a dogma

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We have read with interest the excellent paper by Kollmann *et al.* [1].

The authors affirm that alcohol relapse did not have a statistically significant effect on patient survival.

Pfitzmann *et al.* [2] claim that post-transplant survival is significantly lower in patients undergoing a true relapse than in abstainers or in those with minor lapses, otherwise transplants for alcoholic liver disease (ALD) have mortality rates that are equal to or minor in comparison with transplants for all other causes. Besides, mortality due to relapse of the disease is very low; the leading causes of death are due to cardiovascular diseases and tumors [3].

It is well known that the 6-month rule is an arbitrary threshold and the correlation between 6 months abstention and alcohol relapse is weak [3,4].

A new way of working is needed to improve the results [3].

An Italian position statement affirms that the 6-month rule is not an evidence-based practice [5] and suggests the following criteria:

1 Screening of novo tumors after liver transplantation (LT) (ethanol is present in group 1 of the International Agency for Research on Cancer) [6] and prevention of metabolic syndrome;
2 In cases of end-stage liver disease (ESLD) with a model for end-stage liver disease (MELD) <19, a 6-month period of abstinence could be required;
3 In cases of progressive ESLD with MELD >19, 3 months of abstinence are more ideal in selected patients who are particularly compliant. ESLD alcoholics who do not recover within the first 3 months of abstinence die in high percentages [5,7];
4 In cases of severe acute alcoholic hepatitis (MELD > 20) not responding to steroidal treatment, LT is mandatory in selected patients, independent of the sober period achieved.

The transplant team must include an addiction specialist (AS)/hepato-alcohologist, and patients in the post-transplant period have to participate in self-help groups (SHGs).

The important role of addiction specialists and SHGs was observed in our retrospective experience [8]. This casuistry (2005–2010) was revised more recently (unpublished data). Seventy four young alcoholic patients with ALD were quickly enrolled and put onto a multidisciplinary care pathway with an addiction specialist and regular attendance at an SHG. The team was accompanied by an SHG. This group was compared with 157 young patients who for various reasons followed a traditional route with or without irregular attendance at an SHG. The AS was not present on the traditional route. After a period of 5–10 years (age: 25–35 years), univariate and multiple logistic regression analyses were performed (JMP SA, NC, Cary, USA).

Regular attendance at an SHG will guarantee a longer period of sobriety in years than in a group with conventional treatment: 6 (4–7) vs. 3 (3–6) ($P < 0.0001$). Cases of cirrhosis (9.4% vs. 31%; $P < 0.0001$) and hepatocellular carcinoma (4% vs. 14.6%) tend to be lower. Therefore, an AS and participation in an SHG may be determinant during the post-transplant period in the absence of a specified period of pretransplant alcohol abstinence [5,9,10].

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