Updates on chronic liver disease

This issue of the *MJA* brings a focus on chronic liver disease, which was the ninth leading cause of fatal burden in Australia in 2023 and which is largely preventable.[1] Metabolic dysfunction-associated fatty liver disease (MAFLD) is the most common chronic liver condition in Australia;[2] however, to date there has been a lack of clear and current guidance on its detection and management. So why does MAFLD matter? If left unchecked, MAFLD will be an increasingly important public health issue. Although patients with MAFLD are most likely to die from cardiovascular disease or extrahepatic cancers, MAFLD can progress to advanced stages of liver disease, including cirrhosis and liver cancer.[3] Additionally, MAFLD is a condition that often goes undetected, and is frequently asymptomatic, especially in the early stages, with many patients only diagnosed when undergoing tests for other reasons, or following up abnormal liver function tests.[4] Aimed towards individuals working in primary care, Adams and colleagues present a consensus statement summary of evidence-based recommendations covering key clinical areas such as screening and diagnosis of MAFLD, assessment of extrahepatic comorbid conditions and underlying liver disease, and monitoring over time. Importantly, MAFLD should be considered in people with obesity and/or type 2 diabetes, or two or more metabolic risk factors.[5] As such, general practitioners are in a unique position to implement these guidelines, and assess and monitor patient's liver and metabolic health over time.

Hepatitis C virus (HCV) infection, another important cause of liver disease, is fortunately one in which significant progress has been made towards elimination, with the overall hepatitis C notification rate declining by 36% from 2014 to 2023.[6] This decline can partly be attributed to the availability of direct-acting antivirals (DAAs), as well as primary prevention strategies. DAAs are oral medications that are highly effective and widely accessible in primary care — a model that helps to reduce waiting times and improve access to treatment. However, in some cases, people with HCV infection are referred to tertiary centres for management by non-general practitioner specialists, but little is known about the clinical outcomes of DAA treatment in this context. To bridge this knowledge gap, Layton and colleagues described the cascade of care for a subset of 50 patients identified in the Coordinated Hepatitis response to Enhance the Cascade of Care by optimising existing Surveillance systems (CHECCS) cohort who had been referred to specialist care for HCV in Victoria.[7] They found that most patients were offered appointments and attended, and that the majority of patients with HCV infections commenced treatment and achieved sustained viral response. However, patients with a recent history of injecting drugs were less likely to commence treatment in this setting, perhaps due to perceived stigma by hospital staff and other potential personal barriers to treatment, such as having to manage multiple health and social priorities.[8] The authors conclude that while treatment outcomes for those referred to specialist care were good, this may not be ideal for some groups of patients who may be more successfully treated through other models of care.

Progress is being made towards eliminating chronic liver disease, particularly through advancements in treatment of hepatitis C as we work towards the national target of hepatitis C elimination as a public health threat by 2030. However, strategies to sustain uptake of treatment are essential and may require evaluating which models of care work better than others.[9] Assessment and management of MAFLD provides a new challenge and is one that is ideally suited to primary care. It too will require a sustained effort, but with a holistic approach to patient care and the ability to engage patients, general practitioners are ideally placed to implement the new guidelines, support patients with managing modifiable risk factors, as well as refer for specialist care when required. ■

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1 Australian Government Australian Institute of Health and Welfare. The ongoing challenge of chronic conditions in Australia. *AIHW*: 2024. https://www.aihw.gov.au/reports/australias-health/chronic-conditions-challenge (viewed Aug 2025).

2 Robert SK, Majeed A, Glenister K, Magliano D, et al. Prevalence of non-alcoholic fatty liver disease in regional Victoria: a prospective population-based study. *Med J Aust* 2021; 215: 77-82. https://www.mja.com.au/journal/2021/215/2/prevalence-non-alcoholic-fatty-liver-disease-regional-victoria-prospective

3 Ong JP, Pitts A, Younossi ZM. Increased overall mortality and liver-related mortality in non-alcoholic fatty liver disease. *J Hepatol* 2008; 49: 608-612.

4 Iser D, Ryan M. Fatty liver disease - a practical guide for GPs. *Aust Fam Physician* 2013; 42: 444-447.

5 Adams L, Kemp W, Muller K, et al. Assessment of metabolic dysfunction-associated fatty liver disease in primary care: a consensus statement summary. *Med J Aust* 2025; 223: 268-276.

6 King J, Kwon J, McManus H, Gray R, et al. HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2024. Sydney: The Kirby Institute, UNSW, 2024.

7 Layton E, Matthews N, Quinn B, et al. Treatment outcomes for people with hepatitis C referred to tertiary care in Victoria, 2021–22: a retrospective observational study. *Med J Aust* 2025; 223: 265-267.

8 Madden A, Hopwood M, Neale J, Treloar C. Beyond interferon side effects: what residual barriers exist to DAA hepatitis C treatment for people who inject drugs? *PLOS One* 2018; 13: e0207226.

9 Burnet Institute and Kirby Institute. Australia's progress towards hepatitis C elimination: annual report 2024. Melbourne: Burnet Institute, 2024. https://www.burnet.edu.au/media/5nzcvmn2/australias-progress-towards-hepatitis-c-elimination-annual-report-2024.pdf (viewed Aug 2025). ■