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Summary

# Optimised management of severe acute autoimmune hepatitis: What is the best timing for liver transplantation?

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Surgery | Radiology & Imaging | Immunology | Hepatobiliary

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**The speaker presented an approach to managing acute severe autoimmune hepatitis, emphasizing that decisions between corticosteroid therapy and early liver transplantation should be guided by integrated clinical, laboratory, and radiological assessment with response evaluation by day 3 to 7.**

KEY POINTS

- Acute severe autoimmune hepatitis may present as acute liver failure or acute-on-chronic liver failure, both indications for liver transplantation, with the speaker noting diagnosis can be challenging and suggesting the 1999 diagnostic criteria may outperform simplified 2008 criteria in complex fulminant cases
- The speaker stated that treatment guidelines vary, with EASL recommending 0.5-1 mg/kg/day corticosteroids for cases without ALF/ACLF and British guidelines recommending 40 mg/day if INR is below 2.5 and sepsis excluded, representing a trend toward lower steroid doses
- Predictors of treatment failure before steroids included MELD score above 28, INR above 2.46, hepatic encephalopathy grade 2 or higher, ascites, older age, and small liver volume according to multiple studies presented
- The speaker described the ASA score (combining pre-treatment INR, delta INR at day 3, and delta bilirubin at day 3) with a cut-off of -0.9 to predict transplant-free survival, validated in a Portuguese study alongside MELD-sodium at day 3
- Infections represent the main cause of death post-transplant in autoimmune hepatitis patients according to European registry data, though two studies showed no difference in infection incidence between treated and untreated acute severe cases

– The speaker emphasized that therapy response should be assessed very early, between day 3 and day 7 maximum, as timely liver transplantation is life-saving when corticosteroids fail

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