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Summary

Management of autoimmune hepatitis

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Hepatobiliary | Immunology | Pancreas

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This presentation reviews the management of autoimmune hepatitis, emphasizing that early treatment with prednisolone plus azathioprine or mycophenolate improves survival, with complete biochemical response (normalisation of transaminases and IgG at six months) being the key therapeutic goal.

KEY POINTS

- The speaker stated that lack of complete biochemical response is associated with cirrhosis, liver transplantation, and death in a retrospective registry of over 2500 patients, and that early medical therapy improves survival.
- First-line therapy remains prednisolone at 0.5 to 1 mg/kg/day, tapered individually based on clinical and biochemical response, combined with azathioprine (50 mg/day titrated to 1 to 2 mg/kg) or mycophenolate (1.5 to 2 g/day).
- The speaker reported that approximately one-third of patients are not in complete biochemical remission at six months regardless of steroid choice, and that 30 to 40 percent have insufficient response to first-line therapy.
- For intolerance (occurring in 10 to 20 percent), options include switching to mercaptopurine or mycophenolate; for insufficient response, adherence assessment and metabolite testing are recommended before escalating to third-line agents such as tacrolimus, rituximab, or infliximab.
- Treatment withdrawal should only be considered after at least two years of monotherapy remission, with the speaker noting relapse rates of 60 percent at one year and 80 percent at three years, and emphasizing close monitoring for at least three years post-withdrawal.
- In the Q&A, the speaker expressed the view that vaccine-related autoimmune hepatitis flares are a possible but low risk, and that vaccine-induced disease appears to resolve more quickly than classic autoimmune hepatitis.

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