

LIVER TRANSPLANTATION

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Disease recurrence after LT has increased over the past decade, as many more patients are living more than 15–20 years with their liver graft. Disease recurrence after LT can be divided into four main groups: (i) malignant disease, (ii) viral disease, (iii) autoimmune diseases such as primary biliary cholangitis (PBC) and PSC, and (iv) lifestyle-related diseases such as NAFLD and alcoholic liver disease. The severity of recurrence varies from - mild to the development of progressive allograft failure. Despite strict morphological criteria in selecting patients with HCC for LT , tumour recurrence still occurs in 8–20% of cases, being associated with a median survival of 7–16 months after recurrence. The risk factor s for tumour recurrence are larger tumour burden (beyond the Milan criteria), poor tumour biology , microvascular invasion, higher AFP levels, viral aeti - ology and obesity in the recipient, percutaneous biopsy of the tumour leading to spillage of cells, longer waiting time to trans - plant, higher donor age, DCD transplants and higher burden of immunosuppression in the post-transplant period. HBV recurrence has been r eported in 10% of patients after LT . Howev er, new combinations of post-LT prophylaxis, includ - ing hepatitis B immunoglobulin and nucleos(t)ide analogues such as lamivudine, have reduced the recurrence rates and are part of most LT guidelines. HCV recurrence post LT leads to accelerated liver disease and cirrhosis, with reduced graft and patient survival. Factors associated with increased HCV risk or severity of recurrence after LT include older age, immuno - - suppression, HCV genotype 1 and high viral load at LT . The introduction of protease inhibitors in 2011 and direct-acting antiviral agents in 2013 has led to the reduction both of HCV complications requiring LT and of the consequences of recur - rent HCV infection after LT . A utoimmune diseases commonly recur after LT and may need retransplantation. This usually happens when corticosteroids are withdrawn, but patients usu - ally respond rapidly to the reintroduction of steroids with no adverse long-term impact. PBC and PSC can recur in 20% of patients at 5 years, some of which can be de novo secondary disease. Resumption of alcohol use post LT leads to recurrent - ALD and has an overall poor outcome. NAFLD can recur in patients with metabolic syndrome who continue with poor dietary habits post LT , leading to fibrosis in the graft and even - tually needing retransplantation. Prothrombotic conditions such as Budd–Chiari syndrome can recur in the transplanted liver, requiring retransplantation, but with dismal outcomes. - Summary box 89.7 Diseases that recur after L T /uni25CF /uni25CF /uni25CF /uni25CF - /uni25CF /uni25CF - /uni25CF - /uni25CF

Chronic hepatitis B and C PBC PSC Autoimmune hepatitis Alcoholic liver disease (recurrence alcohol consumption) NAFLD Budd–Chiari syndrome Malignant tumours (HCC, hepatoblastoma)

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