Services for liver disease in the United Kingdom

Roger Williams

BMJ 2005;331:858-859
doi:10.1136/bmj.331.7521.858

Updated information and services can be found at:
http://bmj.com/cgi/content/full/331/7521/858

These include:

Rapid responses
You can respond to this article at:
http://bmj.com/cgi/eletter-submit/331/7521/858

Email alerting service
Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Topic collections
Articles on similar topics can be found in the following collections
Liver, including hepatitis and cirrhosis (819 articles)

Notes

To order reprints of this article go to:
http://www.bmjjournals.com/cgi/reprintform

To subscribe to BMJ go to:
http://bmj.bmjjournals.com/subscriptions/subscribe.shtml
Mortality from liver disease is increasing in the United Kingdom. In 2000 liver disease killed more men than Parkinson's disease and more women than cancer of the cervix. The average mortality among patients admitted to hospital with a diagnosis of liver disease was 18.2% in 2004 with a large range, which suggests (once clinical factors have been accounted for) that the standard of care may vary widely from place to place.

Liver disease has many causes, almost all of them increasing in prevalence. Mortality from alcoholic liver disease has doubled in the past 10 years and, as the chief medical officer pointed out in 2001, these deaths occur mainly among men aged 40-60. Fewer than 10% of an estimated 300 000 cases of infection with hepatitis C virus have been diagnosed and the prevalence of the related chronic liver disease is expected to treble by 2020. Moreover 6000 people who are hepatitis B positive are coming into the United Kingdom each year through legal immigration alone. The incidence of primary hepatocellular cancer is increasing, and so is that of cholangiocarcinoma. Steatohepatitis arising from obesity and diabetes—both increasingly prevalent—is also becoming more common and is being referred to in the United States as the new epidemic of cirrhosis.

But are there enough specialist staff and facilities in the United Kingdom to manage these projected increases in liver disease, or even the current workload? One fifth of the 15 000 cases of cancer seen each year with liver metastases may be suitable for resectional surgery, but too few surgeons have expertise in hepatic resections. Management with new antiviral agents of chronic infections with hepatitis C and B viruses is increasingly complex, and in a recent survey only 40% of consultants were providing a fully comprehensive service for people with hepatitis C infection (W Rosenberg, personal communication, 2003). Little national recommendations on treating hepatitis B and C, practice still varies substantially around the country (so called postcode prescribing). Moreover, the managed clinical networks for delivering care for people with...
hepatitis C, heralded by the chief medical officer last year, have not been adequately implemented.

In 2004 I conducted a questionnaire survey on the staffing and facilities of 28 English hospital trusts identified as running hepatology services and known as "liver centres." Relatively few were able to provide a full range of liver services. There were serious shortages of staff at all levels: a third of the centres lacked a designated consultant hepatologist, and in 11 of the 28 units general physicians were sharing the workload with gastroenterologists. Five centres did not have a single specialist nurse for hepatitis, and in four centres the only specialist nurses were for people with alcohol related disorders. Lack of dedicated beds for patients with liver disease was one of the most common limitations to the service. Waiting times for outpatient appointments were generally unacceptable too—more than 20 weeks in three hospitals, and between 11 and 20 weeks in 14. Only seven hospitals were able to offer an urgent appointment within two weeks. An earlier questionnaire survey on training by Ramage also showed the need for a substantial increase in consultant hepatologists.

How can staffing in the United Kingdom be improved? The recent designation of hepatology as a subspecialty of gastroenterology, with one year of the current five years’ training spent in a liver centre, is a step forward. So are the integrated training pathways proposed for academic doctors through the Modernising Medical Careers programme—and the initiatives of the UK Clinical Research Collaboration, which should both help new recruits into academic hepatology.

Liver services need better funding as well as better staffing. The considerable costs of drug treatment and specialised procedures for treatment underline the need for an appropriate funding mechanism within the new national tariff system. And much remains to be done in the commissioning of specialised liver services by primary care trusts. The National Plan for Liver Services UK envisaged that some 10-15 hospital centres would provide specialised services through a series of managed clinical networks, evenly distributed around the country. This is considerably less than the number of hospitals currently identified as liver centres, and these serve a variable number of primary care trusts (range of 1-14, median 6).

The six centres for liver transplantation in the United Kingdom—which receive dedicated funding—fared better than liver centres in last year’s survey, with considerably more facilities for investigation and availability of expert staff. Patients referred to these centres with liver disease not requiring transplantation (which accounted for 30-60% of the total referrals) will benefit from the better facilities. Increasing the number of transplant centres would be one way to provide liver services more widely in the United Kingdom. Large areas of the country currently lack a transplant centre, notably north west England (including Manchester and Liverpool) and the south west peninsula. Clearly, specialised services for liver disease and transplantation will have to improve substantially to meet the considerably increased burden of liver disease that is predicted for the next 20 years.

Roger Williams director University College London, UCL Institute of Hepatology, London WC1E 6HX (roger.williams@ucl.ac.uk)

Competing interests: None declared.


ASCOT: a tale of two treatment regimens

Better blood pressure, fewer deaths, and less diabetes with newer antihypertensive agents

Each year in the United Kingdom alone there are 20 000 preventable deaths from cardiovascular disease attributable to hypertension. Much of the excess mortality and associated morbidity arises from poor control of blood pressure among people known to have hypertension. For the past two years in the United Kingdom, general practitioners have had the prime responsibility for tackling this problem, along with financial incentives to meet targets for detecting and controlling high blood pressure. Yet, despite many clinical trials and guidelines, they may be unsure about which antihypertensive drug to use first and how to combine treatments.

In 2004 the National Institute for Health and Clinical Excellence (NICE) recommended thiazide or thiazide-like diuretics as the first line treatment for most patients, with the addition of β blockers as the next step. This echoed the advice given in the US Joint National Committee’s guidelines the previous year. Near simultaneous guidance from the British Hypertension Society, however, recommended for the first time drugs acting on the renin-angiotensin system—angiotensin converting enzyme (ACE) inhibi-