Calgary Zone webinar Q&A: Monday, February 26, 2024

A Q&A based on the Calgary Zone webinar held on Monday, February 26. Questions can be directed to info@calgaryareapcns.ca.

Question	Answer
Could someone explain why the FIB4 is recommended only for moderate risk and not high risk [on the AUDIT score}?	There should still be FIB-4 done. Pathway will be updated to clarify.
Is there a number of drinks per week that merits a screen even if they don't score high on the audit screen? Or does the Audit screen take that into account?	Audit considers this but the cut off of >/= 10 drinks/wk is a guide to then do the AUDIT
Alcohol use high. LFT normal, Liver US shows fatty liver with pockets of cirrhosis, SWE low risk... just monitor for now?	High amounts of alcohol consumption tends to universally correlate with fatty liver findings. With a SWE low risk and low FIB- 4, the likelihood of cirrhosis, is likely low enough to continue to monitor, and support management of alcohol use disorder
For patients who are previous heavy drinkers. FIB4 q1yr ongoing? Is there a certain amount of time after they stop drinking the risk decreases?	People who have stopped alcohol consumption, need to know if they have cirrhosis- if there is cirrhosis there is a risk of cancer. If FIB 4 high, likelihood of cirrhosis is higher so need liver cancer surveillance. The progression of liver disease, if a person has stopped drinking, is low.
Are there reasons other than alcohol/fatty liver that can cause an elevated FIB 4?	Thrombocytopenia- certain in ethnicities; if AST normal and ALT high, may see false elevated FIB 4
question ? myth or truth about the protective effect of coffee drinkers	epidemiological reports suggest that coffee is beneficial to the liver (caffeinated, filter drip the best) - especially fatty liver - and I do recommend it to my MASLD patients https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4862107/ https://www.elsevier.es/en-revista-annals-hepatology-16-articulo-the-effect-coffee-consumption-on-S1665268120301691

In your opinion, If/when the next UCP budget again underfunds healthcare and specifically primary care, how should family physicians respond?	Question not asked directly during webinar but PLE Dr. Heather La Borde said: “I know things are hard right now. I do see a glimmer of hope on the horizon. I would say 'hang in there.' I think it's coming."
If we have certain issues with PCN which is difficult for the non clinical lead/ are unable to help us can we reach out to you?	Would always encourage a conversation with leadership at the PCN initially. Heather, as the physician lead exec, is available at PLE@calgaryareapcns.ca
I’m curious to know if we accidentally check off CBC and Fib-4, Will the lab run CBC twice? Or (I hope) just once.	If you check, FIB 4 they only do CBC with no diff, so they will likely do both.
Can we do a fib4 instead of the follow up SWE?	Yes- this is part of the paradigm shift that we are presenting today. FIB-4s can be done instead of a follow up SWE.
If I order ALT and FIB-4 without thinking? They will check ALT twice? For example this happens if 2 different providers order the same test.	they only run it once I think and use it to calculate the FIB score - if two different providers order they do sadly run twice due to a historical challenge (two long of a story to go into here)
I see the updated Feb 2024 pathway on specialist link- but the one on AlbertaPathwaysHub is the 2021 version. Is that because this one is specific to Calgary and not provincial?	Yes- that’s correct. The Calgary Zone pathway is customized to the Calgary zone context.
What is the rationale for sqrt(ALT)?	To emphasize the weight of AST vs ALT
Looking at the pathway, it says if FIB4 >2.67 refer directly to hepatology. But do they really have capacity for that? Because I’ve even had a couple patients with higher risk SWE but the referral was declined, when I called I was told they were “lower end” of high risk and there were capacity issues.	Yes, they do, these patients higher risk of a liver event. This is around 10% of patients that are seen in FIB-4 results. They are at higher risk for having a liver related event, therefore would be triaged first.
Given that you said FIB4 less sensitive in that age group, how would you approach alcohol use pathway in patient with AUD under age 45?	It would be appropriate to use the FIB-4 in patients with AUD even for patients younger than 45. First off, we are the first worldwide to use FIB-4 in patients with AUD in a primary care

	pathway. Given that FIB-4 risk of misclassifying younger patients as false negative for significant and advanced fibrosis in diseases such as MASLD or HCV chronic infection, I do not suspect this to happen in patients with AUD. The reason is that these patients will likely have a degree of thrombocytopenia and elevated AST that will still have these patients among high risk groups. Furthermore, we will carry out research to be sure that risk stratification among those patients with FIB-4 is accurate.
If a patient had liver transplant for liver cirrhosis, do you still recommend carvedilol ?	only if they develop cirrhosis post-transplant with significant portal hypertension - otherwise it doesn't need to be continued post-transplant
Is there a contact for RAC	A contact is not yet available. We'll follow up when one is…