

للوصول إلى مجتمع سعودي يتمتع بكبد سليم To Have a Saudi Society With a Healthy Liver

SASLT NEWSLETTER

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Welcome

Note by



Dr. Faisal M. Sanai
Editor

Another day, and another newsletter. So, what is new in the world of liver-related science, and what is holding our interest? Today, on the backdrop of the International NASH Day on 9th June, we intend to shine a light on this disease within Saudi Arabia, and on the efforts being made to understand its burden. In the same vein, we also highlight research across the spectrum of liver disease that is published from different centers across the country. Further, as previously stated, we intend to showcase the top performers among us to gain insights into their success, and to bring together clinicians from different fields of interest under one umbrella, and to collaborate. We cannot be all-inclusive, but we strive to deliver our best. Those of us who will be remembered are the ones pushing forward the boundaries of science, for in doing so we excel and leave our mark. We are hepatologists, hepatobiliary surgeons, and transplant surgeons and physicians. We are a community of like-minded individuals striving to further the cause of liver-related science. We are SASLT.

NASH in Focus

Unmet Need for a Growing Public Health Crisis



Dr. Hussain Badawi



Dr. Khalid Alswat



Dr. Faisal M. Sanai

Non-alcoholic fatty liver disease (NAFLD), the most common form of chronic liver disease, affects 25% of the adult world population. Non-alcoholic steatohepatitis (NASH), the progressive form, affects approximately one in every five individuals with NAFLD. In Saudi Arabia, NASH is a leading cause of chronic liver disease, and has become the most common indication for liver transplantation. Furthermore, with the increasing prevalence of obesity and type 2 diabetes, a parallel increase in the prevalence of NAFLD is to be expected. Despite being a growing public health concern, NAFLD continues to be under-appreciated. According to a recent global study that collected data from 102 countries including Saudi Arabia, no country has a national strategy for NAFLD, and a comprehensive public health response is lacking in all countries.

Although NAFLD can occur in lean individuals, the vast majority of NAFLD patients are obese. In the past few decades, the prevalence of obesity has steadily increased. *“It used to be 10% in 1970s, but it is up to 35% in 2016”* says Dr. Hussain Albadawi, an endocrinologist and obesity board certified physician, at My Clinic International, Jeddah. He added *“We are among the highest in prevalence along with North*

Africa, and among the fastest growing in prevalence”. Whether obesity itself is a disease state or a behavioral abnormality has been a matter of debate for a long time. *“Yes, it most certainly is a disease, and classifying obesity as a disease would certainly change the behavior of patients and clinicians treating these patients, since the perception would impact the behavioral change once we call it a disease rather than a body state, which implies a temporary condition”* advocates Dr. Albadawi.

Most published studies about characteristics of NAFLD among Saudi patients are based on small individual hospital records and have multiple inherent methodological limitations. Therefore, bigger studies in the field are welcome. Dr. Alswat and his research group conducted a multicenter study (Diabetes Metab Syndr Obes. 2021) with the inclusion of 832 NAFLD patients registered in the Systematic Observatory Liver Disease Registry (DOI:10.2147/DMSO.S300051). According to the results, the mean body mass index for NAFLD patients was 35 kg/m². Dyslipidemia was the most common comorbidity (41%), followed by type 2 diabetes (35%) and hypertension (28%). The prevalence of advanced fibrosis varied according to the different definitions used, ranging from 2.5% to 8.6%. For the most part, the disease characteristics were



Dr. Hussain Badawi

Classifying obesity as a **disease** would certainly **change** the behavior of patients and clinicians treating these patients

similar to other international studies. “One observation is that the advanced fibrosis in our study was lower than that in several studies, including a metanalysis, however, in our study the measurement was based on serum-based markers, as many patients were recruited before the availability of transient elastography” says Dr. Khalid Alswat, an associate professor of medicine and the director of Liver Disease Research Center at King Saud University, Riyadh. Although the study helped to fill in some of the missing data, there remain questions to be answered. Dr. Alswat believes that *“Although the data is the largest from the country*

and included important characteristics, it lacks information on anthropometric measurement, data about patient’s lifestyle including diet and exercise, and the level of disease awareness”. He then adds, *“We also lack comprehensive natural history data of NAFLD in our community in addition to determinants of disease occurrence and progression, and large data on impact of different interventions.”*

The prevalence of NAFLD in Saudi Arabia has not been firmly established as population-based studies are lacking. “With the best available evidence, coined with expert opinion, the prevalence of NAFLD in Saudi Arabia is estimated to be around 25%, and 4.2% with NASH” believes Dr. Alswat. Given the paucity of national NAFLD data, Dr. Alswat and his research team utilized a widely used Markov modeling strategy to evaluate the current and future burden of NAFLD in Saudi Arabia (DOI: 10.4103/sjg.SJG_122_18).

They predicted the prevalence of NAFLD and NASH in the year of 2030 to be 31.7% and 6.8%, respectively (Saudi J Gastroenterol, 2018). Lack of a national database, improper disease coding, wide geographical variation in the quality of health coverage and access to care were cited by Dr. Alswat as important challenges in estimating the NAFLD burden in Saudi Arabia. Dr. Alswat expressed concerns about the lack of a national NAFLD strategy despite the alarming NAFLD data *“There is no national strategy in place at present, or in the foreseen future, for this disease that affects 25% of the people, and 5% in its progressive form”*. He added *“A national strategy should include increased disease awareness at multiple levels, national protocols and referral pathways, and support to primary care centers”*



Dr. Khalid Alswat

There is no national strategy in place at present, or in the foreseen future, for this disease that affects **25%** of people, and **5%** in its progressive form

The economic burden of NAFLD on the healthcare expenditure is rather huge and cannot be ignored. Dr. Faisal Sanai and his group investigated the clinical and economic burden of NAFLD/NASH from 2018 to 2030 (Hepatol Int, 2021) in Saudi Arabia and two other Gulf countries (DOI:10.1007/s12072-021-10182-x). *“Our study demonstrated the increasing burden of NAFLD in Saudi Arabia, with rates of serious disease-related sequelae such as cirrhosis and HCC increasing three-fold (> 200,000 cases) over the next decade, and an even greater increase in the rates of liver-related death”* says Dr. Sanai, a leading researcher and hepatologist at King Abdulaziz Medical City, Jeddah. He adds *“The discounted lifetime costs of NAFLD-related-care is expected to reach USD 40 bn, amounting to a substantial drag on the country’s healthcare expenditure”*. As with any modeling study,

the results are only as good as what has been placed into the model inputs and assumptions. "In order to reduce bias in our study, we partnered with third party consultants to gather the data, conduct interviews, and arrive at consensus, thus making our findings as robust as practically possible". The study by Dr. Sanai and colleagues has, no doubt, delivered an important message to the governmental policy makers. "I would urge concerned policymakers in preventive health medicine departments to catch the bull by the horn, so to speak, and take urgent action. While we now have a rough sketch of the burden looming ahead of us, we must do more to obtain real-life, on the ground, validated data to further understand the nature of the burden" says Dr. Sanai.



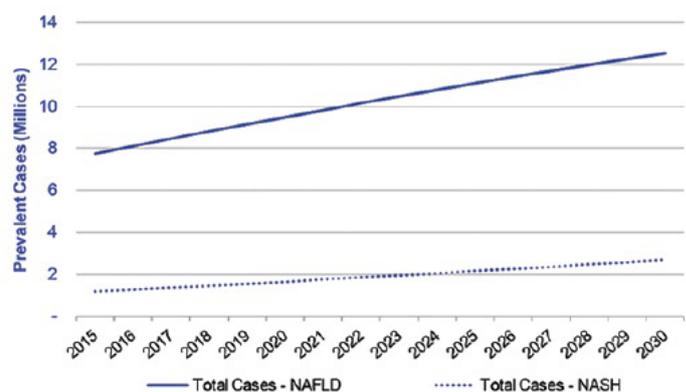
Dr. Faisal Sanai

Everything in **NAFLD is an unmet need**, right from disease awareness, screening, identification, linkage-to-care, and eventual treatment

When it comes to managing patients with NAFLD, multiple obstacles exist, and several gaps are still to be filled. In a recent review, Dr. Sanai and his coauthors discussed management of NAFLD in the Middle East. When asked what is unmet in NAFLD care, Dr. Sanai promptly answered: "Everything in NAFLD is an unmet need, right from disease awareness, screening, identification, linkage-to-care, and eventual treatment". At the level of screening, there is an ongoing confusion on whom screening for NAFLD should be offered. "A simplistic answer would be to say, anyone who is overweight, has diabetes or metabolic syndrome, or has unexplained elevation in liver enzymes. Unfortunately, this would include more than half of the adult population" says Dr. Sanai. Another ongoing challenge in managing patients with NAFLD is the difficulty in distinguishing simple steatosis from NASH, with the latter group at risk of disease

progression. "We lack a simple tool to distinguish between these two forms of NAFLD, and the implications for this are huge. The current method of liver biopsy is just not an option given the huge burden of the disease in the general population. There must be a concerted effort to devise and develop non-invasive biomarkers that can reliably and reproducibly distinguish between these two forms of the disease". Given the burden of the disease, it would be impossible for hepatologists alone to take care of all patients. "We must recruit and partner with other healthcare services, principally with general practitioners, internists, endocrinologists and cardiologists" Dr. Sanai advocated.

While the NAFLD burden is expanding, treatment continues to be a challenge with the lack of effective pharmacological interventions. Dozens of drugs have been investigated but only a few have reached phase III of drug development, and none obtained regulatory approval. At present and for the foreseeable future, weight reduction continues to be the main target. Without preventive measures, the clinical and economic burden of NAFLD will be substantial. It is time for the healthcare policy makers to put in place a national strategy to address this growing public health crisis and limit the burden of NAFLD on the healthcare system.



Prevalent cases of NAFLD/NASH in Saudi Arabia 2015 -2030



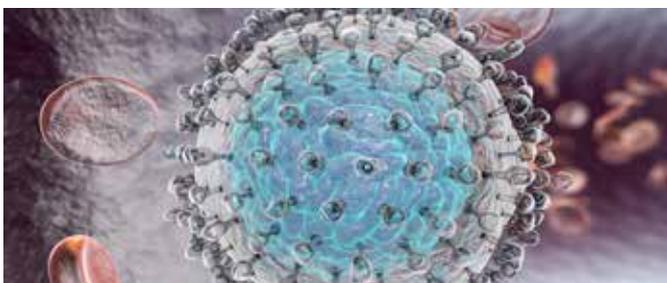
Dr. Majid Alsahafi

Efficacy of Elbasvir/Grazoprevir Combination for 8 Weeks in HCV Treatment and Health-related Quality of Life (HRQoL) in Treatment-naïve, Non-cirrhotic, Genotype 4-infected Patients (ELEGANT-4)

AlEid A, et al. *Saudi J Gastroenterol.* 2022;28(3):225-232. doi: 10.4103/sjg.sjg_374_21.

The current treatment of hepatitis C infection with direct acting antiviral (DAA) regimens is expensive, remaining as one of the main challenges in treating patients on a large scale. Multiple DAA-based regimens have been in use for HCV treatment since 2014. In this single-center, single-arm, open-label, phase 3 trial the authors evaluated the efficacy and safety of a shortened course of Elbasvir (ELB)/Grazoprevir (GZR) of 8 weeks than the usual 12 weeks and changes in health and hepatitis related quality of life (HRQoL) in patients who are treatment naïve, non-cirrhotic and mono-infected with HCV genotype 4.

Of the 30 patients enrolled, 29 (97%) achieved sustained virological response at weeks 4 and 12 post-therapy (SVR-4 and SVR-12). In this trial, 53% of the patients experienced adverse events, however, no serious adverse events were associated with the course of treatment. Additionally, significant improvements were found in all parameters that were used to evaluate the patients' HRQoL between the first (baseline) and third (SVR-12) timepoints. Furthermore, this was the first study to evaluate the effects of a shorter treatment duration using hepatitis-specific indices.



Validating Controlled Attenuation Parameter in Assessing Hepatic Steatosis in Living Liver Donors

Broering D, et al. *PLoS ONE* 2021;16(5):e0251487
doi:10.1371/journal.pone.0251487. eCollection 2021.

Hepatic steatosis (HS) adversely impacts transplant outcomes in living liver donors. Currently, liver biopsy is the gold standard for assessing HS. The aim of this study was to validate the use of controlled attenuation parameter (CAP) as a diagnostic tool for HS in living liver donors.

This was a prospective, single-center, cohort study in the Liver Transplant Unit at King Faisal Specialist Hospital and Research Centre from April 2016 to February 2020. Of the 150 potential donors, 73.3% were males; 61.3% had no or mild HS based on CAP, while 38.7% and 10% had moderate to severe HS based on CAP and liver biopsy, respectively. The sensitivity, specificity, positive predictive value and negative predictive values of CAP to detect significant HS were 93.3%, 67.4%, 24.1% and 98.9%, respectively. The receiver operating characteristics (AUROC) value for CAP was 0.841. On multiple logistic regression, higher ALT was predictive for moderate to severe HS. This study suggests that CAP can be used as a noninvasive and simple method of identifying and excluding significant HS in living liver donors.

Long-Term Outcomes of Liver Transplantation for Patients with Autoimmune Hepatitis

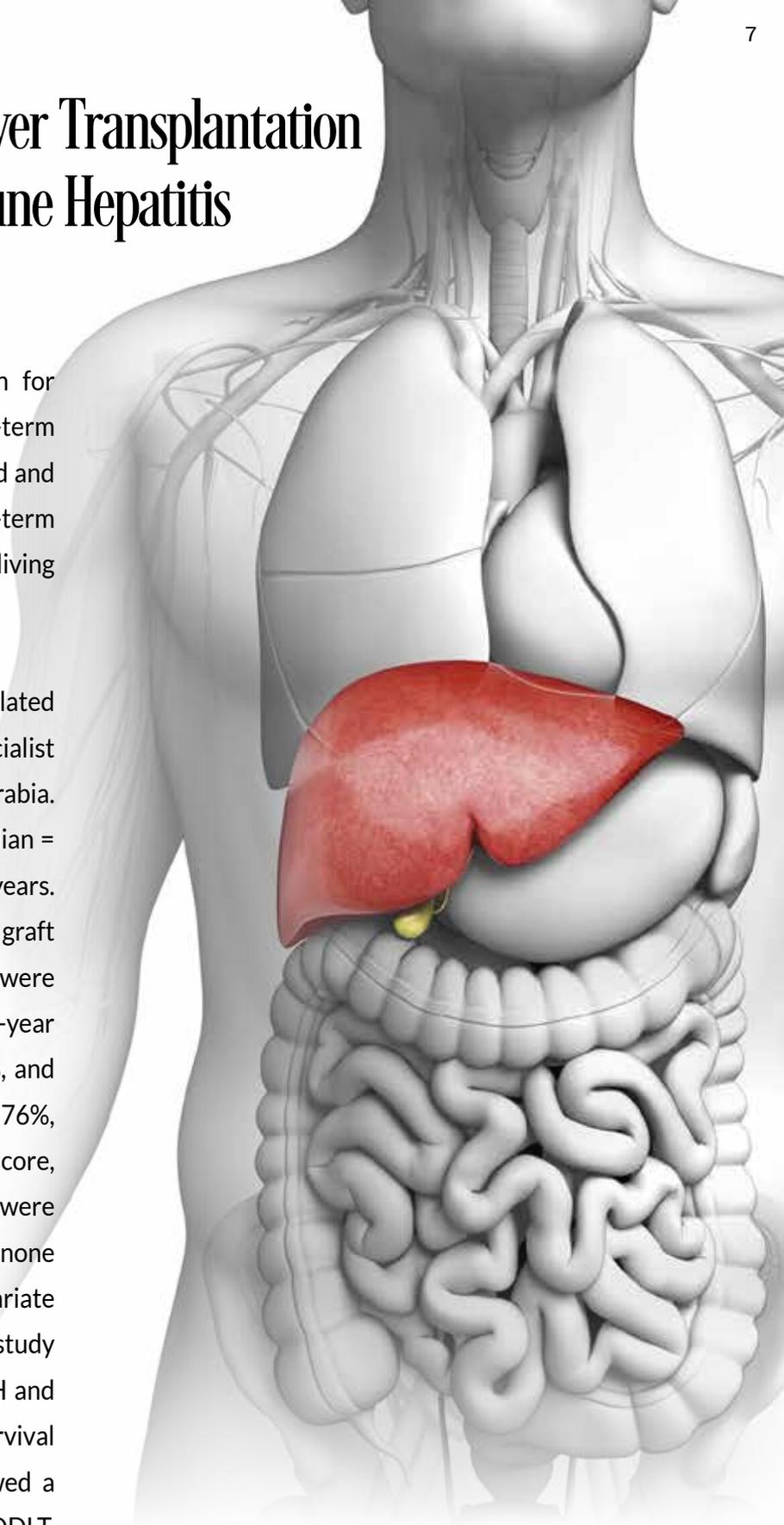
Alswat K, et al. *Transplant Proc.* 2021;53(7):2339-2345.
doi: 10.1016/j.transproceed.2021.07.040.

Liver transplantation (LT) is a rare indication for autoimmune hepatitis (AIH). Data on the long-term outcomes of living-related LT for AIH are limited and inconsistent. This study assessed the long-term outcomes of deceased donor LT (DDLT) and living donor LT (LDLT) for AIH.

A total of 74 patients received LT for AIH-related cirrhosis from 2001 to 2018 at King Faisal Specialist Hospital & Research Center in Riyadh, Saudi Arabia. The average follow-up was 7.9 ± 6.9 years (median = 7.2 years) and the average age was 34.3 ± 13.8 years. Almost half of the (49.3%) patients received a graft from a living donor, and 83% of patients were maintained on steroids. The 1-, 3-, 5-, and 10-year survival rates of patients were 91%, 89%, 87%, and 82% and of grafts were 89%, 88%, 86%, and 76%, respectively. In univariate analysis, MELD score, donor age, donor type, and renal function were significant predictors of graft survival; however, none of the factors remained significant in multivariate analysis. This study is the largest single-center study evaluating long-term outcomes of LDLT for AIH and highlighted the excellent patient and graft survival rates post LT for AIH. In addition, LDLT showed a slightly better long-term survival rate than DDLT, with one of the lowest reported recurrence rates. It is possible that standard management and immunosuppressive therapy, including a low-dose steroid regimen, contributed to their successful outcome.



Dr. Mona H. Ismail



Liver injury after SARS-CoV-2 vaccination

Efe C, et al. *Hepatology* 2022; doi.org/10.1002/hep.32572

In a multi-center retrospective study of 87 patients from 18 countries, the clinical characteristics, efficacy of steroids and outcomes of patients who developed liver injury following SARS-CoV-2 vaccination was assessed.

New-onset liver injury was defined as elevations of ALT or AST $\geq 5x$ upper limit of normal (ULN) and/or alkaline phosphatase (ALP) $\geq 2x$ ULN or ALT/AST $\geq 3x$ UNL and bilirubin $\geq 2x$ ULN. Liver injury was categorized as: (1) mild if enzyme elevations reached criteria for liver injury but bilirubin concentration was $<2x$ ULN; (2) moderate if either bilirubin $\geq 2x$ ULN or symptomatic hepatitis; (3) severe if bilirubin $\geq 2x$ ULN and signs of liver failure (INR ≥ 1.5 , ascites and/or encephalopathy) or other organ failure considered to be due to liver injury; and (4) fatal if death from liver disease or the need for liver transplantation due to liver injury.

Vaccine-related liver injury was more common in females (63%) and 28% of patients had pre-existing autoimmune disorders before liver injury onset. Pre-existing liver disorders were reported in 12 patients (7 with NASH, 2 with AIH in remission, 1 with PBC, 1 cleared HCV and one post-transplant for PSC). In regards to the type of vaccine, 59% of



patients had Pfizer - BioNTech vaccine, 23% had Oxford-Astrazeneca 18% had Moderna vaccine.

Most patients (92%) were symptomatic at presentation; fatigue (75%), nausea (63%) and jaundice (39%) were the most reported symptoms. The pattern of liver injury was hepatocellular in (84%), mixed in (10%) and cholestatic in (6%). The severity score for liver injury was grade 1 in 43.7%, grade 2 in 35.6%, grade 3 in 19.5% and grade 4 in 1 patient.

Features of immune-mediated hepatitis (positive autoimmune markers and high IgG) were seen in 57% of the patients. Among 44 patients who had liver biopsies, 34 were ascribed as probable/definite AIH according to simplified criteria. Corticosteroids were given to 46 (53%) patients, more often for grade 3-4 than for grade 1-2 liver injury (88.9% vs 43.5%, $p=0.001$) and more often for patients with than without immune mediated hepatitis (71.1% vs 38.2%, $p=0.003$). All patients showed resolution of liver injury except for one (1.1%) who developed liver failure and underwent liver transplantation. A second immunosuppressive drug was used in 11 patients

(Imuran in 9 and MMF in 2 patients). Plasma exchange was performed in 9 patients. Immunosuppression was withdrawn in 26% (12/46) of the patients during the study period and none of these relapsed after 44-140 days of follow-up. Similarly, 41 cases who showed spontaneous resolution of liver injury did not develop relapse during a median 69 days of (35-172) follow-up.

Systematic review of response criteria and endpoints in autoimmune hepatitis

Pape S, et al. *J Hepatol.* 2022; 76: 841-849. DOI: 10.1016/j.jhep.2021.12.041

The treatment goal in autoimmune hepatitis (AIH) is to reduce long-term liver-related morbidity and mortality and to improve quality of life in these patients. Defining the response to treatment is

important to develop surrogate endpoints, contribute to better understanding of outcomes and improve reporting of results in clinical trials.

The study group from the International Autoimmune Hepatitis Group (IAIHG) identified systematic reviews of trials reporting outcomes of treatment in AIH since January 2010, and practice guidelines and consensus statements or recommendation regarding the management of AIH. The authors used a modified Delphi approach in which each endpoint of interest was given a number of possible definitions by 11 members from IAIHG and they drafted the study survey. All members of IAIHG were then invited to complete the survey. A total of 75 respondents from 220 invited members (34%) completed the survey, and the workshop was attended by 50 participants.

The table below summarizes the endpoints for AIH treatment as proposed by the IAIH working group after a consensus process.

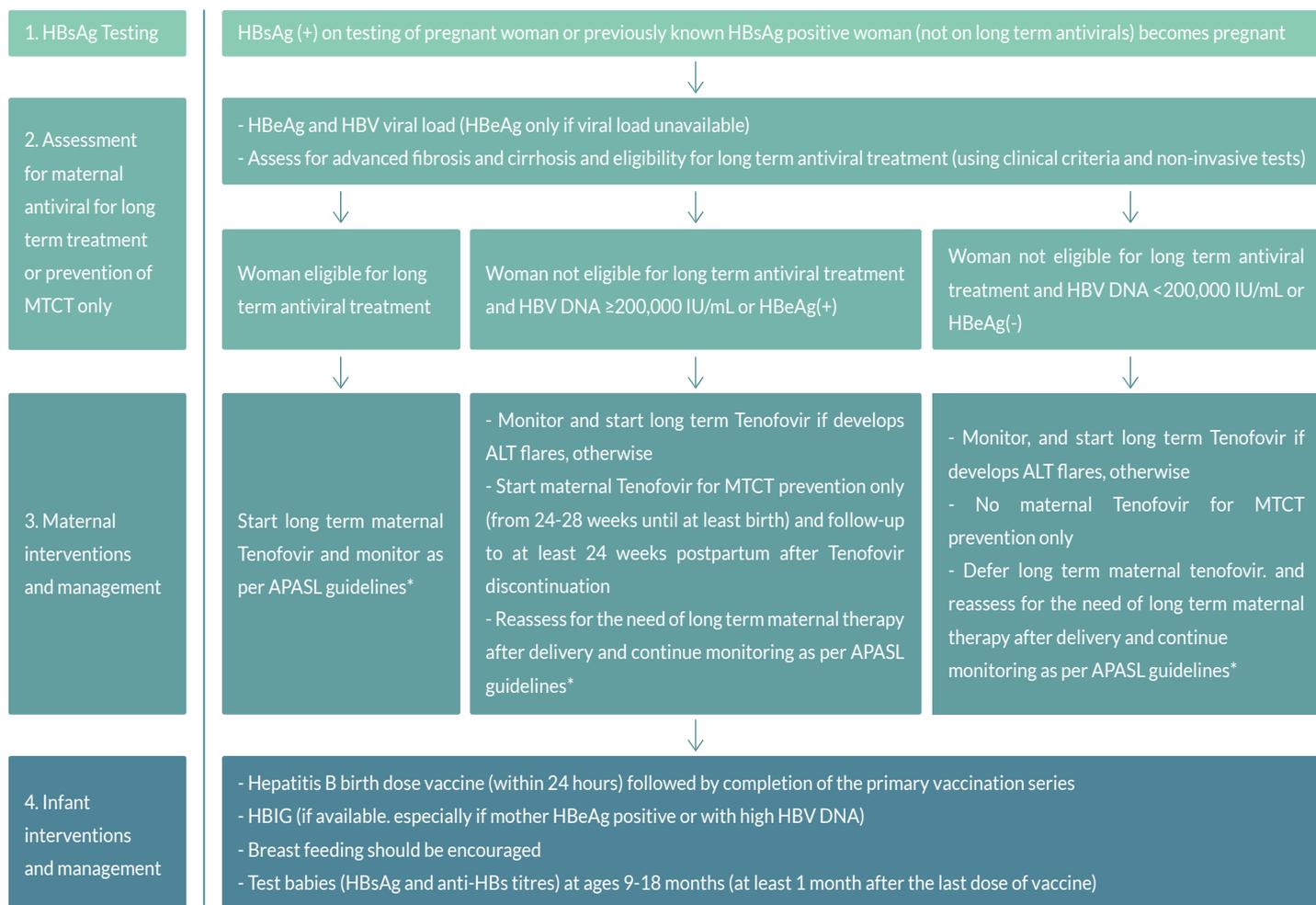
Endpoint	Definition
Complete biochemical response	Normalisation of serum transaminases and IgG below the ULN. Should be achieved no later than 6 months after initiation of treatment
Insufficient Response	Lack of complete biochemical response. Should be determined no later than 6 months after initiation of treatment.
Non Response	<50% decrease of serum transaminases within 4 weeks after initiation of treatment.
Remission	Hepatitis activity index <4/18.
Intolerant to treatment	Any adverse event possibly related to treatment as assessed by the treating physician leading to potential discontinuation of the drug.

Asian Pacific Association for the Study of Liver (APASL) guidelines: Hepatitis B virus in pregnancy

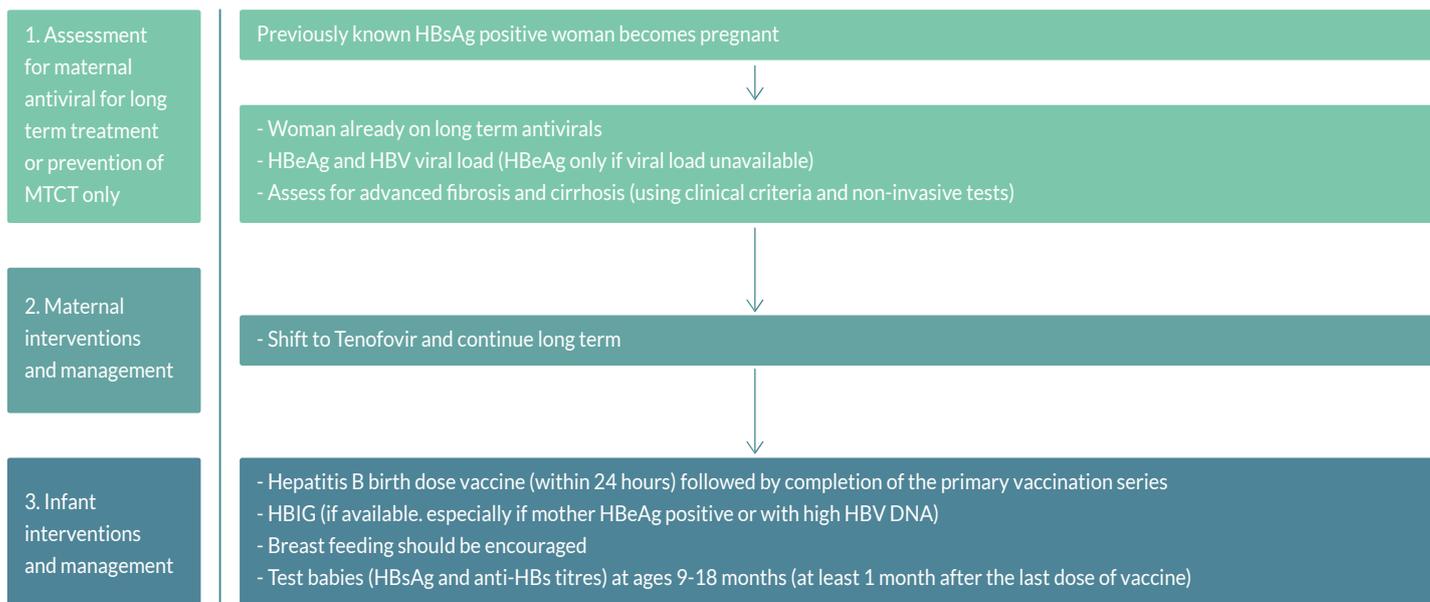
Kumar M, et al. *Hepatol Int* 2022;16:211–253. doi.org/10.1007/s12072-021-10285-5

The Asian Pacific Association for the Study of Liver (APASL) has recently released the guidelines for the management of hepatitis B virus (HBV) in pregnancy. These guidelines are of immense importance to hepatologists and gastroenterologists since pregnant women infected with HBV represent a special population with unique management issues for both the mother and fetus. Since HBV infection in infancy or early childhood often leads to chronic infection, it is important to take appropriate measures to prevent mother-to-child transmission. The paper comprehensively covers the epidemiology of HBV in pregnant females in Asian Pacific countries, immunopathogenesis of HBV infection in pregnancy, how HBV infection affects the health of pregnant females and the outcome of pregnancy, the impact of pregnancy on HBV infection severity, and prevention of mother-to-child transmission and breast feeding in HBV-infected mothers.

The below figure schematically summarizes the most important recommendations of these guidelines:



*MTCT = Mother-to-Child Transmission



* Asian-Pacific clinical practice guidelines on the management of hepatitis B: a 2015 update [Reference 259]



Dr. Ali H. Albenmoussa



The Excellence Corner

Interview with Prof. Mohammed Alsebayel

Editor: *Can you describe your journey in this field, from inception to the present time?*

I was born and raised in Unaizah, a city that is at the forefront of education in the Najd region, and in the Kingdom of Saudi Arabia as a whole. Teaching and learning were greatly valued by the society, and students competed for grades with dreams of going to the university in Riyadh. My biggest influence was my father, himself a teacher being immersed in the education process for a good part of his life. Life as a budding student was not easy, more so for the challenges and ever-greater expectations that I set for myself. Moving to Riyadh from Unaizah in secondary school required coping with the difficulties of a new environment balanced against the expectations placed on me by my parents and family. I was always a good student and ranked among the top five students in the high school exams Kingdom-wide. My childhood dream was to be a doctor, and I fulfilled this when I graduated with honors in 1981. Then followed my surgery residency in Canada and subsequent fellowship in 1987 from UK, after which I joined King Khalid University Hospital as an Assistant Professor. Around this time in 1989, Thomas Starzl, a pioneer in liver transplantation surgery, visited the Kingdom at the invitation of National Guard Health Affairs and I was fortunate to be approached for a 2-year transplant fellowship in Pittsburgh, USA. Returning back to the country after completing this training, I established the first liver transplant program outside of the industrialized world at the King Fahd National Guard Hospital in 1991. Subsequently, I established the Hepatobiliary Unit at King Khalid University Hospital and then moving on to King Faisal Specialist Hospital & Research Center – Riyadh in 2001, I established the cadaveric liver transplant program, followed by the living donor liver transplant (adult and pediatric) program a year later. For the next decade and a half, I dedicated my life and profession to the transplant program until my retirement in 2018.

- Alsebayel

Editor: *What are the challenges that you faced in reaching the pinnacle of your career?*

Early training in general surgery was the physical and psychological equivalent of a never-ending marathon. As an associate consultant, I would take the on-calls from other surgeons in trying to gain more experience. Training in Pittsburgh was brutal, dealing with the physical and mental strain of sleepless nights, long

operating room procedures and managing extremely sick liver disease patients. The biggest challenge of my life, however, was the establishment of the liver transplant program at the King Fahd National Guard Hospital in the early 1990s. To gear up to house a liver transplant program I had to work with almost every single department in the center to align them towards our goal of performing the first liver transplantation surgery. With the establishment of the program, this advanced service further propelled the medical facility into an advanced tertiary care center. This service obviously benefitted other specialties in the hospital thus contradicting the belief that a transplant program consumes and absorbs resources from other services. It so happened that during the years between 1994 and 1998 the transplant program attracted a lot of attention especially in the media, which brought positive and negative reactions towards the program.

Moving to King Faisal Specialist Hospital & Research Center in 2001 was the second challenge. The center's previous attempt between 1994 and 1998 to launch a liver transplant program led by a team from outside the Kingdom had not been successful and this burdened me with the huge pressure of restarting the program and making it sustainable. The initial success was not enough to propel the program as it struggled with the constraints imposed by the many high calibre services in the hospital competing for resources. This consumed a lot of my time, energy and efforts, and exerted immense mental and psychological strain.

The other big challenge was organ donation and organ shortage, which was handled by a not so organized health care system that was struggling to increase organ donation in the country. The system was held back by a lack of clear understanding of the needs and peculiarities of organ transplantation. In aiming to bridge this gap in organ donation, I established The Mobile Donor Action Team, which between 2006 and 2013 tripled the donation in Riyadh. A proof of concept was demonstrated. I believe that organ shortage in the Kingdom is an organizational problem rather than a cultural or religious dilemma.

- Alsebayel

A visit to King Fahad National Guard Hospital by HRH Prince Abdallah bin Abdulaziz after the first liver transplant surgery in 1994



Editor: Can you list (what you believe are) your achievements in this field?

I believe that my biggest achievement was the introduction of liver transplantation in our country when I established the program in King Fahd National Guard Hospital, thus helping our patients with liver diseases to have their transplantation inside the country rather than travelling abroad for this service. Reestablishment of the liver transplant program in King Faisal Specialist Hospital & Research Center was another major achievement. Introduction of the Living Donor Liver Transplant Program as early as 2001 in keeping up with the rapid progress and trying to overcome the organ shortage crisis was another achievement. On the academic side, I have been active in training and teaching for over 3 decades, and published over 90 research articles in national and international journals, not to mention a similar number of abstract presentations in local and international conferences

- Alsebayel



| During internship in 1982

Editor: Can you name a few things that you feel you have been unable to achieve (as your unfulfilled ambitions)?

Throughout my professional life my goal was to be able to provide end-stage liver disease patients with a permanent solution for their disease and restore them to normal life. My dream was to establish a liver institute that would provide care to all aspects of liver disease rather than just liver transplantation. I feel that this job was not completed despite the establishment of the liver disease center which solely provides liver transplantation service, and not a comprehensive liver care service that I had eagerly aspired for. Another big disappointment was being unable to set up an ongoing, self-sustaining organ donation service

that could transform the field of organ transplantation in the Kingdom in a very dramatic way. Additionally, while I managed to establish an excellent national liver transplant team, towards the end of my tenure the team lost its coherence, ending with the migration of several members to other hospitals and some of them leaving the liver transplant field.

- Alsebayel



The liver transplant team in King Faisal Specialist Hospital & Research Centre in Riyadh, Saudi Arabia in 2014

Editor: What message would you like to pass on to your peers, colleagues, and the fresh graduates of hepatobiliary and liver transplant surgery?

My message to my colleagues is to put patients first in any clinical or other activity. In our field, the patient mix that we deal with is unique in their needs and challenges. Our decisions will impact the rest of their lives in a very dramatic way. The devotion towards liver patients, in my opinion, is unique in clinical practice. Remember that once a patient has a liver disease, he will need care for the rest of his life, and it is this devotion and commitment that will sustain them.

Today, I see the unfortunate spectacle of less cooperation between transplant programs. Adopting a win-win approach will certainly benefit everyone, and for this we need to do away with any negative competitiveness. Fortunately, the liver community in the Kingdom is realizing this and through organizations such as SASLT, people in the field are being brought together. We are in an era of transformation and this calls for a national reform for the management of liver diseases and organ donation. I truly hope to see this as part of the Kingdom's Vision 2030. Finally, we, the older colleagues should support and mentor the younger generation who through their energy, passion and collaborative spirit can truly achieve what our generation could not.

- Alsebayel



Dr. Faisal M. Sanai



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and Transplantation

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To Have a Saudi Society With a Healthy Liver