Alcohol and the Liver

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Data from the Office for National Statistics shows that liver disease has risen to fifth place in the list of causes of mortality in the United Kingdom. However, unlike the top four causes which include coronary artery disease, cerebrovascular disease, respiratory disease and cancer, liver disease mortality is rising rather than falling. In the majority of liver related deaths alcohol is either the primary cause or a major contributory factor. The reason for the increasing mortality from alcoholic liver disease is clear; we as a society are consuming more alcohol. However, the relationship between alcohol consumption and liver disease is not straightforward; not everyone who consumes excessive amounts of alcohol will develop significant liver disease. It is estimated that only 10-15% of alcoholics will develop alcoholic hepatitis and/or cirrhosis (Mann 2003). The risk of developing alcoholic liver disease is related to the blood alcohol concentration and the duration of raised blood alcohol concentration. These parameters are determined by the pattern of drinking (daily versus binge) and total alcohol consumption (quantity and frequency). There are large inter-individual variations in the rate of alcohol elimination (Li 2001) which indicate that blood alcohol concentrations and risk of developing alcoholic liver disease are influenced by genetic variation in the alcohol metabolising enzymes.

Patterns of alcohol consumption affect the risk of developing liver disease. The term ‘binge drinking’, currently beloved and misused by the media, is formally defined as consumption of 5 or more units (50g) of alcohol in 2 hours in males and 4 or more units (40g) in 2 hours in females. Binge drinking is undoubtedly a marker of an alcohol use disorder and may be associated with violent behaviour, risky sexual behaviour and emergency hospital admissions. However, it is frequent, heavy drinking which results in alcoholic liver disease rather than binge drinking. Nevertheless early binge drinking in teenagers may progress to drinking. Nevertheless early binge drinking in teenagers may progress to binge drinking. Nevertheless early binge drinking in teenagers may progress to drinking. Nevertheless early binge drinking in teenagers may progress to drinking.
patients who consume excess alcohol. It should be noted, however, that liver disease is not the only physical consequence of excess alcohol consumption. Alcohol causes a range of neurological disorders, ranging from peripheral neuropathy to dementia. Chronic pancreatitis, muscle damage and cardiac damage are caused by alcohol and may develop independently or coexist with liver damage.

In conclusion it is important to recognise the range of diseases to which alcohol contributes and the extent of morbidity and mortality attributable to this recreational drug. It is estimated that £2.9 billion a year of NHS resources are spent on alcohol related disorders but these statistics hide a much greater burden of social and emotional costs (Royal College of Physicians 2001). Effective action to control alcohol consumption is therefore urgently required.

References
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Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

The Commission on Social Determinants of Health, set up by the World Health Organisation to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it, is a global collaboration of policy-makers, researchers, and civil society led by Commissioners with a unique blend of political, academic, and advocacy experience. Importantly, the focus of attention embraces countries at all levels of income and development: the global South and North.

The Commission takes a holistic view of social determinants of health. The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally; the consequent unfairness in the immediate, visible circumstances of people’s lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.

A new approach to development
Health and health equity may not be the aim of all social policies but they