Considerations specific to Covid 19

Mild abnormalities in ALT <3xULN will be common post Covid-19.
Acute liver injury reported in severe Covid-19 in ICU setting but unlikely to be seen in primary care post-Covid patients.

Approximately 25-30% of tested population in Leeds have abnormal ALT.
Check any past LFTs. If abnormalities pre-date Covid-19 please investigate aetiology as per guidance from LTHT.

Patients hospitalised with Covid-19 more likely to have diabetes and/or be overweight/obese. These are both risk factors for fatty liver disease.

Check alcohol history, this is also a risk factor for fatty liver disease. If regular intake of >14units/week advise to stop all alcohol in first instance.

Stop any NSAIDS. Do not introduce statins at this stage.

If abnormalities are mild, statins could be continued in diabetic patients etc. If stopped remember to reintroduce once LFTs settled/evaluated.

Initial investigations

ALT <x3ULN and new: Monitor monthly. It should normalise. Investigate at 3 months if not. Follow LTHT guidance for investigation of abnormal LFTs. Ferritin may be high due to inflammatory response - follow-up with iron studies if so.

ALT >x3ULN and new: Monitor again 2-4 weeks. Investigate at 1 month if not normalised or reducing. Follow LTHT guidance for investigation of abnormal LFTs. Ferritin may be high due to inflammatory response - follow-up with iron studies if so.

Start to address any history of excess alcohol, optimise diabetic control, introduce exercise as possible.

Isolated raised bilirubin: Request conjugated/unconjugated bilirubin split. Gilberts syndrome common and characterised by predominantly unconjugated bilirubin. May be provoked by illness. Gilberts can co-exist with other conditions. Bilirubin levels most usually between 17 and 50.

Isolated raised ALP: Optimise vitamin D levels, Consider Ultrasound scan (to check biliary tract) with Doppler (to check vascular supply); Check BNP as cardiac impairment may give this picture.

Red flags

Jaundice not attributable to Gilberts syndrome or not in isolation.

Acute liver injury ALT>10xULN

Start investigations immediately and refer for specialist opinion

Useful documents which may not yet be widely available

(1) LTHT guidance for risk stratifying patients with fatty liver disease.
This is not yet on line but has been agreed.
Fib-4 should be available on the GP facing ICE but if not there yet it is easily calculated on line. GP needs ALT, AST and platelet count and patient age.

(2) Our approach to investigating possible Gilberts syndrome.