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Your Patient's PBC Treatment: Long-Term Monitoring and Management

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Kowdley:
This is CME on ReachMD. I'm Dr. Kris Kowdley. Here with me today is Dr. Marlyn Mayo.

After treatment for PBC has begun, what about monitoring? What biochemical markers do providers need to be testing?

Dr. Mayo:
Right. Well, it is of course important to monitor our patients, and that's really because the current treatment paradigm is a stepwise approach where patients are started on first-line therapy with ursodeoxycholic acid, or ursodiol, and then they're monitored for a biochemical improvement, typically about every 6 months. And then if the biochemical improvement is inadequate, then a second-line therapy should be considered because there's data that clearly show that patients whose liver biochemistries improve significantly have a better survival than those whose liver biochemistries don't.

Now, which biochemistries are important to follow and how much they need to improve is a topic that we have recent updates in the field. So we've known for decades, for example, that bilirubin is the strongest serological predictor prognosis in PBC, but there's some more recent data from the Global PBC Group that's shown us that a patient whose bilirubin is in the lower part of the normal range actually has a better survival than someone who has a bilirubin that may be normal but in the upper part of the normal range.

And we now know that alkaline phosphatase is a serological marker that can predict survival 10, even 15 years down the road. And then another useful marker to follow is GGT [gamma-glutamyl transferase], which appears to be a much more dynamic marker of PBC activity. It's less specific, but it often rises even before the alkaline phosphatase does, and it drops more rapidly with treatment.

In summary, I think providers should follow liver tests about every 6 months and pay special attention to the bilirubin, the alkaline phosphatase, and the GGT because these are the 3 that have proven prognostic value. And what we want for our patients is to have the bilirubin that is less than 0.6 times the upper limit of normal, an alkaline phosphatase that's within the normal range, and a GGT that is less than 3.2 times the upper limit of normal.

And also with these patients, with respect to monitoring, you know, there's routine health screening that is important. And in particular, we monitor bone density, thyroid function because patients with PBC are at increased risk for osteoporosis and autoimmune hypothyroidism, and also staying up to date with vaccines, particularly those hepatitis vaccines such as A and B.

Dr. Kowdley:
As you very nicely summarized, the emerging data show very clearly that our goal is not to just reduce the alkaline phosphatase from baseline but to try and achieve normal, if we can, and ideally maintain a total bilirubin of less than 0.6 times the upper limit of normal.

You also highlighted the importance of monitoring patients for disease stage because that independently predicts outcomes. And last but not least, how a team approach is required to provide holistic care for the patient, with attention paid to bone density measurement, thyroid function testing, looking for anemia, breast cancer surveillance, et cetera, et cetera.

So thank you for these insights, Dr. Mayo, and thank you to our listeners for tuning in.

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