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LETTER TO THE EDITOR: SEQUENTIAL ASSESSMENT OF LIVER FIBROSIS IN THE ERA OF MASLD NOMENCLATURE

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TO THE EDITOR

We read with great interest the study by Tramontin et al.[1] regarding the prevalence of liver fibrosis in Southern Brazil using magnetic resonance elastography (MRE). Their findings of a high prevalence of advanced fibrosis (20.2%) in a retrospective cohort are a significant contribution to the regional epidemiological landscape. However, some points regarding current nomenclature and screening strategies warrant further discussion.

According to the 2023 multi-society consensus, NAFLD was renamed metabolic dysfunction-associated steatotic liver disease (MASLD) to emphasize its metabolic origins[2]. The diagnosis now requires hepatic steatosis plus at least one cardiometabolic criterion, such as type 2 diabetes mellitus or increased waist circumference. In the study published by Tramontin et al.[1], 55 patients presented steatosis (46.2%), while 10 were diabetic (8.4%). Although the prevalence of concomitant steatosis and diabetes was not explicitly described, the association between diabetes mellitus and increased liver stiffness reinforces the relevance of metabolic dysfunction in this population.

The clinical suspicion of fibrosis in MASLD, integrated with non-invasive blood-based biomarkers such as the Fibrosis-4 (FIB-4) score, is increasingly important to prioritize patients for advanced imaging techniques like MRE. Recent dose-response studies[3] have demonstrated that as proton density fat fraction (PDFF) increases, the odds of developing prediabetes and diabetes mellitus also rise significantly, reinforcing the close relationship between hepatic steatosis, metabolic dysfunction, and fibrosis risk.

In this context, incorporating simple non-invasive tools such as FIB-4 into the evaluation of metabolically high-risk patients may help identify individuals with clinically relevant fibrosis at earlier stages, supporting more timely referral for advanced imaging assessment[4]. Additionally, the elevated prevalence of advanced fibrosis observed in the study by Tramontin et al.[1] should be interpreted considering the potential referral bias inherent to a cohort of patients already referred for MRE evaluation in a tertiary radiology center, likely enriching the sample with individuals at higher risk for chronic liver disease.

In conclusion, the high prevalence of fibrosis reported by Tramontin et al.[1] reinforces the importance of sequential, non-invasive strategies for fibrosis risk stratification in patients with metabolic dysfunction. Integrating clinical, laboratory, and imaging-based approaches may contribute to earlier recognition of advanced liver disease and improved patient management.

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