



Letters to the editor

Reply to letter to the editor



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Editor in Chief of Annals of Hepatology

I greatly appreciate the Annals of Hepatology policy of having an open forum where scientific disagreements can be discussed. Dr. Segundo Moran raised two interesting points concerning the role of previous liver diseases such as chronic infection with hepatitis B (CHB) or C (CHC) and the excessive alcohol consumption on the prevalence of non-alcoholic fatty liver disease (NAFLD), defined by a non-invasive risk score, that we found in our paper entitled: "Prevalence and predictors of elevated liver enzyme levels in Mexico: The Mexican National Health and Nutrition Survey, 2016" [1]. We consider the comment to the CHB and CHC and its relationship with NAFLD a valid point. In this sense, unfortunately the subjects included in our analysis did not have information regarding the prevalence of CHB and CHC, which was an important limitation of the study. However, a recent analysis [2] of the Mexican National Health and Nutrition Survey (ENSANUT, by its Spanish acronym) 2018 observed a prevalence of hepatitis B virus (HBV) infection of 0.51% (95%CI 0.19, 2.33); in this sense, and given that the prevalence of HBV infection is small, we do not consider that there would be changes in the prevalence of NAFLD or in the estimations we presented in our manuscript. Additionally, previous studies have suggested that subjects with CHB patients with CHB have reduced incidence of hyperlipidemias and NAFLD [3,4]. Concerning the effect of the excessive alcohol intake and NAFLD, it is true that 54% of the population included in our analysis reported having ever consumed alcohol. Despite the fact, at the time of our analysis there was no more detailed information on alcohol intake recorded by 24 dietary recalls. Actually, in the subjects included in our analysis the average alcohol intake was 4.2 gr; while, the average intake in those who reported alcohol intake the previous day of the interview was 9.2 gr (13.4 gr/day for men and 5.5 gr/day for women), in both cases, and considering the recommendation of the World Health Organization [5], the average ethanol intake per day can be usefully classified as "Low risk" (<20 g/day for women and <40 g/day for men), "Medium risk" (>20 and <40 g/day for women and >40 and <60 g/day for men) and "High risk" (>40 g/day for women and >60 g/day for men), the consumption in the study population was low, with only 68 subjects with moderate to high intakes. Taking this information into account, we deleted those subjects with high intakes of alcohol and the results did not significantly change (data not shown). Furthermore, we did not delete those with low intake because two recent meta-analysis [6,7] suggested that modest alcohol intake was associated significantly with lower risk of NAFLD. However, the recommendation for low alcohol drinking should be made cautiously considering the clinical context of each patient.

Finally, previous reports suggest that in México the consumption of ultra-processed products (UPP), including sugar sweetened beverages (SSBs), is expanding. For example, the energy contribution of UPP to household's purchases increased from 10.5% kcal in 1984 to 23.1% kcal in 2016 [8]. Furthermore, considering the socio-economic status (SES), in subjects with a low SES, 30.3% of the calories consumed come from processed or UPP [9]. Also, López-Olmedo et al., [10] found that the highest intake of SSBs is observed in the low SES group. In the Mexican population, these data could be related with the high prevalence of NAFLD in the low and medium SES groups. However, more detailed analysis should be conducted to analyze this relationship. We also should consider these factors, among others, as important contributors of the burden of the chronic diseases, including NAFLD, in Mexico.

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