LETTERS TO THE EDITOR

Readers are encouraged to write letters to the editor concerning articles that have been published in Clinical Gastroenterology and Hepatology. Short, general comments are also considered, but use of the Letters to the Editor section for publication of original data in preliminary form is not encouraged. Letters should be typewritten and submitted electronically to http://www.editorialmanager.com/cgh.

Letter to the Editor: On the Proposed Definition of Metabolic-Associated Fatty Liver Disease

Dear Editor:

We read with interest the comment from the Editors, recently published in *Clinical Gastroenterology and Hepatology*, regarding the proposed definition of metabolic-associated fatty liver disease (MAFLD).[1]

We agree with the Editors that the proposed disease acronym MAFLD is more appropriate than nonalcoholic fatty liver disease (NAFLD). This is because, compared with NAFLD, MAFLD is more descriptive, inclusive, and nonexecutory, and encompasses the associated metabolic dysfunction of hepatic steatosis.

Two population-based, cross-sectional studies that compared the 2 definitions were cited by the Editors.[2,3] In these studies, although there was substantial overlap between the 2 definitions, with 80%–90% of patients with hepatic steatosis meeting the criteria for both NAFLD and MAFLD, there was a nonnegligible proportion of individuals meeting criteria for one but not the other definition.

We recently described the results of a prospective, community-based, cohort-study in suburban Sri Lanka, evaluating new-onset metabolic traits (MTs) and cardiovascular events after a 7-year follow-up among patients defined as NAFLD and MAFLD versus control subjects without hepatic steatosis.[4] At baseline, out of 1028 study participants with hepatic steatosis, 902 (87.7%) met both definitions, 8.6% met the definition of MAFLD but not NAFLD, and 3.7% met the definition of NAFLD but not MAFLD. At baseline, anthropometry and MTs were similar in the NAFLD and MAFLD groups. At follow-up after 7 years, the risk of new-onset MTs and fatal/nonfatal cardiovascular events were also similar in the 2 groups, but were significantly higher in both these groups compared with control subjects. However, at follow-up after 7 years, those excluded by the NAFLD definition but captured by the MAFLD definition showed higher baseline MTs compared with those excluded by the MAFLD definition but captured by the NAFLD definition, and had substantially higher risk for having new-onset MTs and cardiovascular events compared with control subjects.

We concluded that, although it was able to increase the index population by only a small proportion, redefining NAFLD as MAFLD seemed to improve clinical utility. However, we agree with the Editors that more evidence is required from larger, longer-term outcome studies from varying populations before strong recommendations can be made to replace NAFLD with MAFLD in clinical practice.

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Conflicts of interest
The authors disclose no conflicts.

Most current article
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Endoscopic Bariatric and Metabolic Therapies on Nonalcoholic Fatty Liver Disease: Enough Data to be Considered Effective?

Dear Editor:

We read with great interest the article by Jirapinyo et al[1] on "The effect of endoscopic bariatric and metabolic therapies on nonalcoholic fatty liver disease: a systematic review and meta-analysis." After conducting a meta-analysis, the authors conclude that endoscopic bariatric and metabolic therapies (EBMTs) seem to be effective at treating nonalcoholic liver disease (NAFLD). However, even though their methodological approach was rigorous, we think that the level of evidence of the studies included in this systematic review is too low to draw such conclusions.

The authors should be commended for choosing regression of liver fibrosis as the primary outcome of this systematic review, because this histologic endpoint is