Expert consensus on management of metabolic disease in Chinese liver transplant recipients

Tian Shen, Li Zhuang, Xiao-Dong Sun, Xiao-Sheng Qi, Zhi-Hui Wang, Rui-Dong Li, Wen-Xiu Chang, Jia-Yin Yang, Yang Yang, Shu-Sen Zheng, Xiao Xu

ORCID number: Tian Shen 0000-0003-0302-4895; Li Zhuang 0000-0003-4773-2287; Xiao-Dong Sun 0000-0002-3666-5739; Xiao-Sheng Qi 0000-0002-4545-6656; Zhi-Hui Wang 0000-0002-1351-1390; Rui-Dong Li 0000-0002-9766-2005; Wen-Xiu Chang 0000-0001-6269-5694; Jia-Yin Yang 0000-0002-3176-2599; Yang Yang 0000-0003-4981-4745; Shu-Sen Zheng 0000-0002-9745-5065; Xiao Xu 0000-0002-2761-2811.

Author contributions: Shen T designed the primary structure of this consensus with the help of Zhuang L, under the supervision of Zheng SS and Xu X; this paper was mainly written by Zhuang L and Shen T, with the contribution of Sun XD, Qi XS, Wang ZH, Li RD, Chang WX, Yang JY, and Yang Y.

Supported by the National Science and Technology Major Project of China, No. 2017ZX10203025; National Natural Science Funds for Distinguished Young Scholar of China, No. 81625003; National Natural Science Foundation of China, No. 81930016.

Conflict-of-interest statement: All the authors have no conflict of interest related to the manuscript.

Open-Access: This article is an open-access article that was

Tian Shen, Shu-Sen Zheng, Xiao Xu, Department of Hepatobiliary and Pancreatic Surgery, The First Affiliated Hospital, Zhejiang University School of Medicine, Hangzhou 310003, Zhejiang Province, China Li Zhuang, Shu-Sen Zheng, Department of Hepatobiliary and Pancreatic Surgery, Shulan (Hangzhou) Hospital, Hangzhou 310003, Zhejiang Province, China Xiao-Dong Sun, Department of Hepatobiliary and Pancreatic Surgery, The First Hospital, Jilin University, Changchun 130021, Jilin Province, China Xiao-Sheng Qi, Department of General Surgery, Shanghai First People's Hospital, School of Medicine, Shanghai Jiao Tong University, Shanghai 200080, China Zhi-Hui Wang, Department of Hepatobiliary and Pancreatic Surgery, The First Affiliated Hospital of Zhengzhou University, Zhengzhou 450052, Henan Province, China Rui-Dong Li, Department of General Surgery and Liver Transplant Center, Huashan Hospital, Fudan University, Shanghai 200040, China Wen-Xiu Chang, Department of Nephrology, Tianjin First Center Hospital, Tianjin 300384, China Jia-Yin Yang, Department of Liver Surgery and Liver Transplantation Center, West China Hospital of Sichuan University, Chengdu 610041, Sichuan Province, China Yang Yang, Department of Hepatic Surgery and Liver Transplantation Center, The Third Affiliated Hospital of Sun Yat-sen University, Guangzhou 510630, Guangdong Province, China

Corresponding author: Xiao Xu, MD, PhD, Chief Doctor, Professor, Surgeon, Department of Hepatobiliary and Pancreatic Surgery, The First Affiliated Hospital, Zhejiang University School of Medicine, No. 79, Qingehun Road, Hangzhou 310003, Zhejiang Province, China. zjxu@zju.edu.cn

Abstract

Metabolic disease, including diabetes mellitus, hypertension, dyslipidemia, obesity, and hyperuricemia, is a common complication after liver transplantation and a risk factor for cardiovascular disease and death. The development of metabolic disease is closely related to the side effects of immunosuppressants.
Core tip: This consensus aims to provide recommendations for the prophylaxis and treatment of metabolic disease in Chinese liver transplant recipients to improve the long-term survival of the recipients. The principles of prophylaxis and treatment include lifestyle modification, individualization of immunosuppressive regimen, and drug therapy. In addition to the contents related to diabetes mellitus, hypertension, and dyslipidemia, this edition of consensus also includes the related contents of hyperuricemia and obesity, aiming at guiding the standardized management of metabolic disease in a more comprehensive way.

Citation: Shen T, Zhuang L, Sun XD, Qi XS, Wang ZH, Li RD, Chang WX, Yang JY, Yang Y, Zheng SS, Xu X. Expert consensus on management of metabolic disease in Chinese liver transplant recipients. World J Gastroenterol 2020; 26(27): 3851-3864
URL: https://www.wjgnet.com/1007-9327/full/v26/i27/3851.htm
DOI: https://dx.doi.org/10.3748/wjg.v26.i27.3851

FOREWORD

Thanks to mature surgical techniques and standardized perioperative and long-term management, the survival rate of Chinese liver transplant recipients has gradually improved. According to the Report on the Medical Quality of Liver Transplantation in China in 2018[6], mortality within 1 wk after liver transplantation decreased from 3.7% in 2015 to 2.2% in 2018; the 3-year cumulative survival rate was 78.51% in liver transplant recipients with benign end-stage liver diseases and 75.87% in those with hepatocellular carcinoma who met Hangzhou Criteria. This means that the survival in Chinese liver transplant recipients has reached the international leading level as described in the annual data report 2018 of Organ Procurement and Transplant Network/Scientific Registry of Transplant Recipients[1]. However, chronic diseases after liver transplantation, including metabolic disease, chronic kidney disease, and cardiovascular diseases, are increasing year by year. Metabolic complications, including diabetes mellitus, hypertension, dyslipidemia, obesity, and hyperuricemia, are common after liver transplantation.

Relevant reports show that the incidence rates of diabetes mellitus, hypertension, dyslipidemia, hyperuricemia, and obesity are 30%-40%[11], over 50%[10], 40%-66%[9], 14%-53%[12], and 18%-30%[13,14], respectively, and tend to increase with time after liver transplantation[15]. Metabolic disease is closely associated with the development of chronic kidney disease, infections, and cardiovascular diseases and greatly affects the quality of life and long-term survival of recipients[15,16]. However, metabolic disease can be prevented and treated through early intervention. This consensus is aimed at providing recommendations for the prophylaxis and treatment of metabolic disease in Chinese liver transplant recipients to improve the long-term survival of the recipients.
RECOMMENDATIONS FOR THE PROPHYLAXIS AND TREATMENT OF METABOLIC DISEASE IN LIVER TRANSPLANT RECIPIENTS

Effective immunosuppressive therapy is essential for ensuring the long-term survival of liver grafts after liver transplantation [14], but long-term use of immunosuppressive agents can lead to or aggravate post-transplant metabolic disease. Different immunosuppressive agents have different effects on metabolic disease. Calcineurin inhibitors (CNIs), including tacrolimus (TAC) and cyclosporine A (CsA), are often associated with hypertension, diabetes mellitus, dyslipidemia, and hyperuricemia; glucocorticoids are associated with hypertension, diabetes mellitus, obesity; mammalian target of rapamycin (mTORi) inhibitors are associated with dyslipidemia. However, mycophenolic acids (MPA), represented by mycophenolate mofetil (MMF), and antibody drugs such as rabbit antithymocyte globulin and basiliximab have no effect on metabolic disease (Table 1). Studies have found that basiliximab induction, combined with MMF and the glucocorticoid-free or early withdrawal regimen, or MMF combined with the dose-reduced CNI can decrease the occurrence of immunosuppressive agent-caused metabolic disease and adverse effects by ensuring immunosuppressive efficacy in liver transplant recipients [15-21]. Therefore, based on the improvement of dietary structure and lifestyle, metabolic disease should be well managed through individualized selection of appropriate immunosuppressive agents at a minimum dose according to clinical characteristics of recipients and the use of additional drugs when necessary. It requires involvement of the follow-up doctors of liver transplant recipients when the immunosuppressive regimes need adjustment.

Recommendation 1: The prophylaxis and treatment of post-liver transplantation metabolic disease should be based on changes in dietary habits and lifestyle, paying attention to the adverse effects of immunosuppressive agents, advocating personalized medication. The regimen with basiliximab induction and glucocorticoid-free or CNI minimization containing MPA is feasible.

Prophylaxis and treatment of diabetes mellitus

Post-transplant diabetes mellitus (PTDM) includes pre-existing diabetes mellitus and new-onset diabetes after transplantation (NODAT) in liver transplant recipients. PTDM is a common complication that occurs after solid organ transplantation [22]. In recent years, a considerable number of recipients are diagnosed as diabetes after transplantation because preoperative diagnosis of diabetes has not been standardized. In this case, it cannot be determined whether the patients develop NODAT. As a result, PTDM has been widely used. The 2019 diagnostic criteria for diabetes established by the American Diabetes Association are: fasting plasma glucose (FPG) ≥ 7.0 mmol/L (126 mg/dL), 2 h blood glucose during oral glucose tolerance test ≥ 11.1 mmol/L (200 mg/dL), glyated hemoglobin (HbA1c) ≥ 6.5%, or random plasma glucose ≥ 11.1 mmol/L (200 mg/dL) (Table 2) [24,25]. The incidence of pre-transplantation diabetes mellitus is about 33% [26], and that of NODAT is 30%-40% [27]. PTDM is mainly characterized by insulin resistance with chronic progression on symptoms. It presents both the characteristics of type 2 diabetes mellitus (T2DM) and serious complications of type 1 diabetes, such as ketoacidosis [28]. PTDM increases the risks of rejection, infection, cardiovascular events, and death [29,30]. The 2017 Consensus on Managing Modifiable Risk in Transplantation recommends that the blood glucose control target after liver transplantation should be: fasting blood glucose < 6.7 mmol/L (120 mg/dL), peak blood glucose < 8.88 mmol/L (160 mg/dL), or HbA1c < 7% [31].

The main mechanisms of PTDM include decreased insulin sensitivity and β cell failure. PTDM is associated with many factors, such as hepatitis C virus infection, family history of diabetes mellitus, body mass index, immunosuppressive agents, etc. Among immunosuppressive agents, glucocorticoids, CNIs, and mTORi (including sirolimus and everolimus) are the most important pathogenic factors [29,32]. See Figure 1 for details. Studies have shown that the blood concentration of TAC higher than 8 ng/mL at 3 mo after liver transplantation is an independent risk factor for PTDM [33]. On the other hand, polymorphism of diabetes-related genes in donors and recipients has also been confirmed to be associated with PTDM. At present, it is believed that genetic background of T2DM will greatly increase the risk of diabetes. Molecular genetics of diabetes mellitus is more and more widely studied and has been applied in early genetic diagnosis, clinical treatment, and primary prophylaxis of diabetes mellitus. Gene diagnosis provides important clues for the study of diabetes pathogenesis. The studies of the First Affiliated Hospital of Zhejiang University and Shanghai Jiao Tong University School of Medicine have pointed out that ADIPOQ rs1501299 [29] and SUMO4 rs237025 [30] of the donor and the recipient are associated with
PTDM, which will contribute to better managing PTDM.

For diabetic liver transplant recipients, the treatment should be based on diet therapy, lifestyle modification, including exercise and weight loss (for obese recipients), and further adjustment of the immunosuppressive regimen and appropriate use of hypoglycemic drugs. Some studies have shown that the risk of NODAT increases by 5%\(^{[31]}\) with a prednisone dose increase of 0.01 mg/kg. Compared with conventional glucocorticoid-based regimens, glucocorticoid-free or early withdrawal regimens can significantly reduce PTDM\(^{[32,33]}\), while the use of basiliximab and MPA makes the glucocorticoid-free or early withdrawal regimen safe and feasible. Several other studies have shown that the fasting blood glucose level and glycosylated hemoglobin level in liver transplant recipients with PTDM decreased significantly after conversion from TAC to CsA\(^{[34,35]}\). For liver transplant recipients with poor blood glucose control [expressed as continuously elevated blood glucose level (> 11 mmol/L) and HbA1c (> 9%)], conversion from TAC to CsA or the combination of MMF and low-dose TAC is recommended\(^{[22,26]}\).

In the early post-transplant period, insulin should be adopted in the presence of obvious hyperglycemic symptoms or markedly elevated glycosylated hemoglobin level before liver function is normal\(^{[36]}\). According to the available evidence, it is essential and safe to keep the average blood glucose < 10 mmol/L and HbA1c < 8% in the first week after liver transplantation while using insulin as a prophylaxis strategy\(^{[29]}\). Moreover, insulin is the best choice when using high-dose glucocorticoids. With the extension of post-transplantation time, the oral hypoglycemic agents can be started when the insulin dose is reduced to less than 24 units daily. Oral hypoglycemic agents need to be selected based on the renal function of the recipients. Biguanide drugs, such as metformin, which are cleared mainly through the kidneys, can only be

---

### Table 1 Adverse effects of immunosuppressive agents on post-liver transplant metabolic disease

| Metabolic disease | Glucocorticoids | CNIs (TAC) | CNIs (CsA) | mTORi | MPA | Antibody drugs (ATG/basiliximab) |
|-------------------|----------------|------------|------------|-------|-----|---------------------------------|
| Diabetes mellitus | +++            | +          | +          | +     | -   | -                               |
| Hypertension      | +              | ++         | ++         | -     | -   | -                               |
| Dyslipidemia      | +              | +          | +++        | -     | -   | -                               |
| Obesity           | +              | +          | +          | +++   | -   | -                               |
| Hyperuricemia     | -              | ++         | +          | -     | -   | -                               |

CNI: Calcineurin inhibitor; TAC: Tacrolimus; CsA: Cyclosporine A; mTORi: Mammalian target of rapamycin; MPA: Mycophenolic acids.

### Table 2 2019 diagnostic criteria for diabetes and prediabetes by American Diabetes Association\(^{[24,25]}\)

| Diagnosis                     | ADA criteria                                                                                                                                                                                                 |
|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diabetes                      | FPG ≥ 126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h. OR 2-h PG ≥ 200 mg/dL (11.1 mmol/L) during OGTT. The test should be performed as described by the WHC, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water. OR A1C ≥ 6.5% (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay. OR in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, an FPG ≥ 200 mg/dL (11.1 mmol/L). |
| Prediabetes                   | FPG 5.6-6.9 mmol/L (100-125mg/dL) (IFG) OR 2HPG 7.8-11.0 mmol/L (IGT) OR A1c 5.7%-6.4%                                                                                                                     |

\(^{[1]}\)In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples. ADA: American Diabetes Association; RPG: Random plasma glucose: refers to the blood glucose level at any time regardless of the time of the last meal in 1 d; FPG: Fasting plasma glucose; OGTT: Oral glucose tolerance test; 2HPG is the blood glucose level 2 h after OGTT; HbA1c is glycosylated hemoglobin; the symptoms of diabetes mellitus include polyuria, polydipsia and unexplained weight loss. Intravenous blood glucose levels must be measured on the next day once the blood glucose level is detected abnormal to confirm the diagnosis. Hyperglycemia caused by specific acute metabolic abnormalities must be excluded; DCCT assay: Diabetes Control and Complications Trial assay.
safely applied in recipients with estimated glomerular filtration rate above 60 mL/min/1.73 m², while sulfonylureas, such as glipizide and glimepiride, can be used in both and are more preferred for recipients with impaired renal function[38].

Recommendation 2: The blood glucose target after liver transplantation is: Fasting blood glucose < 6.7 mmol/L (120 mg/dL), peak blood glucose < 8.88 mmol/L (160 mg/dL), or HbA1c < 7.0%.

Recommendation 3: Minimization of the dose of glucocorticoids and MPA combined with CNI reduction can reduce the occurrence of PTDM. For liver transplant recipients with poorly controlled blood glucose expressed as continuously elevated blood glucose (> 11 mmol/L) and HbA1c levels (> 9%), converting TAC to CsA is recommended.

Recommendation 4: Insulin is recommended when glucocorticoids are used intravenously and the liver function is not fully recovered. When the dose of insulin is reduced to less than 24 units per day, oral hypoglycemic drugs are recommended if the liver function is normal. Metformin or sulfonylureas can be used in recipients with normal renal function, while sulfonylureas, such as glipizide and glimepiride, are preferred in recipients with impaired renal function.

Prophylaxis and treatment of hypertension

Hypertension is defined as: In the absence of antihypertensive medications, systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg measured three times on different days. Hypertension occurs in more than 50% of liver transplant recipients, and the incidence increases over years with the prolongation of the survival[4]. About 47% of the recipients develop hypertension at 1 to 3 mo after transplantation[9]. Hypertension is a major risk factor for renal insufficiency[44] and cardiovascular disease[41] after liver transplantation. The 2017 Consensus on Managing Modifiable Risk in Transplantation group recommends that the blood pressure target should be under 130/80 mmHg[27], while for recipients with renal injury, it should be below 125/75 mmHg[42].

Hypertension after liver transplantation has complex causes and is associated with multiple factors. The risk of post-operative hypertension increases significantly in obese or diabetic recipients[45].

Immunosuppressive agents such as CNIs and glucocorticoids are the main risk factors for new-onset hypertension after liver transplantation. The main mechanism of CNI-induced hypertension is to induce increased systemic circulatory resistance and further influence renal blood flow while glucocorticoids increase vascular resistance and myocardial contractility mainly through their mineralocorticoid effect[46]; see Table 3 for the specific mechanisms. Other risk factors include elderly age, genetic

---

**Figure 1 Risk factors for post-liver transplant diabetes mellitus**[3]. PTDM: Post-transplant diabetes mellitus; CNI: Calcineurin inhibitor; mTORi: Mammalian target of rapamycin; HCV: Hepatitis C virus; CMV: Cytomegalovirus.
Table 3 Relevant mechanisms of hypertension after liver transplantation induced by common immunosuppressive agents\textsuperscript{[42]}

| Category | Drug           | Mechanism                                                                 |
|----------|----------------|---------------------------------------------------------------------------|
| CNI      | TAC, CsA       | Increasing vascular tension: reducing nitric oxide (NO) and increasing endothelin level  
Activating the angiotensin-aldosterone system: elevated blood pressure, water, and sodium retention  
Activating sodium-chloride synergistic transport receptors in distal tubules: increased sodium reabsorption and excessive capacity  
Nephrotoxicity: AKI induced by vasoconstriction Chronic ischemia, glomerulosclerosis, interstitial fibrosis, and tubular atrophy |
| Glucocorticoid | Methylprednisolone | Increasing sympathetic excitability  
Increasing vascular tension  
Increasing activity of mineralocorticoids |

CNI: Calcineurin inhibitor; TAC: Tacrolimus; AKI: Acute kidney injury; CsA: Cyclosporine A.

To control post-liver transplant hypertension, firstly, physicians should comprehensively assess the risk factors associated with the recipients. The existing risk factors should be avoided, and active intervention measures such as changing the unhealthy lifestyle, limiting salt in diet, controlling body weight, taking appropriate sports activities, etc., should be taken\textsuperscript{[43]}. Personalized immunosuppressive regimens should be formulated based on the constitutions of the recipients. The risk of hypertension caused by immunosuppressive agents can be reduced to a certain extent by adjusting the immunosuppressive regimen, for example, minimizing the immunosuppressive agents (CNIs and glucocorticoids) that may cause hypertension. The risk of hypertension caused by CsA is higher than that caused by TAC\textsuperscript{[46]}. However, the regimen of MPA represented by MMF combined with CNI reduction regimen can significantly reduce the risk of new-onset hypertension after liver transplantation, and the glucocorticoid-free or early withdrawal regimen can also significantly reduce the incidence of new-onset hypertension after liver transplantation\textsuperscript{[47-50]}. If the target blood pressure cannot be achieved by changing the lifestyle and adjusting the immunosuppressive regimen, antihypertensive drugs should be used\textsuperscript{[42]}. Common antihypertensive drugs include calcium channel blockers (CCBs), angiotensin-converting enzyme inhibitors (ACEIs), angiotensin II receptor blockers (ARBs), β-blockers, and diuretics. Because CCBs can directly counteract the vasoconstriction induced by CNIs, they are often used as first-line agents in recipients without proteinuria. Dihydropyridine CCBs (such as nifedipine, amlodipine, nicardipine, etc.) are preferred due to their relatively decreased medication interaction as compared with the nondihydropyridine CCBs\textsuperscript{[51]}. However, nondihydropyridine CCBs (verapamil and diltiazem) should be used cautiously because they can significantly increase the bioavailability of CNIs. For hypertensive recipients with proteinuria, ACEIs and ARBs can be used as first-line drugs as they can reduce proteinuria\textsuperscript{[47]}, but they should be used cautiously when renal function is significantly impaired. The treatment of hypertension with diuretics is mainly suitable for recipients with excessive circulatory blood volume during the early post-transplant period\textsuperscript{[52]}. If the blood pressure cannot be controlled at an appropriate level through single-agent therapy, CCBs and ACEIs or ARBs can be used conjunctively.

Recommendation 5: The blood pressure target after liver transplantation is: Blood pressure < 130/80 mmHg and target blood pressure < 125/75 mmHg for recipients with renal injury.

Recommendation 6: The regimen with minimization of glucocorticoids and the combination of MPA and CNI reduction can reduce post-liver transplant hypertension.

Recommendation 7: CCBs, ACEIs, and ARBs should be used as first-line antihypertensive agents. ACEIs and ARBs are suitable for liver transplant recipients with proteinuria.
Prophylaxis and treatment of dyslipidemia

Chinese Society of Organ Transplantation Standard for the Management of Blood Lipids in Solid Organ Transplant Recipients 2019 points out that dyslipidemia refers to the abnormal elevation of total cholesterol (TC), triglycerides (TG), or low density lipoprotein cholesterol (LDL-C) in the blood. The normal blood lipid levels in the Chinese population are: TC < 5.18 mmol/L (200 mg/dL), TG < 1.7 mmol/L (150 mg/dL), LDL-C < 3.37 mmol/L (130 mg/dL), and HDL-C ≥ 1.04 mmol/L (40 mg/dL). With an incidence of 40%-66%, post-liver transplant dyslipidemia is one of the important risk factors for cardiovascular disease. The treatment aim dyslipidemia is LDL-C < 2.59 mmol/L (100 mg/dL), and it is LDL-C < 1.8 mmol/L (70 mg/dL) in those with cardiovascular risk factors.

Risk factors for dyslipidemia include dietary habits, age, body mass, other metabolic complications (such as diabetes, hypertension, obesity, etc.), genetic factors, and drugs. After liver transplantation, the use of immunosuppressive agents, especially mTORi, CNIs and glucocorticoids, is the main cause of dyslipidemia. Different CNIs have different effects on blood lipid levels. CsA and mTORi can more effectively reduce blood lipid levels than TAC and mTORi glucocorticoids, respectively. mTORi increases blood lipid levels by increasing liver lipid synthesis, reducing lipid clearance, and inhibiting insulin and insulin-like growth factor pathway. CNIs increase blood lipids mainly by reducing bile acid synthesis, down regulating LDL receptor function, inhibiting cholesterol clearance, inducing cholesterol synthesis, and promoting the conversion of very low-density lipoprotein cholesterol to LDL.

For the treatment of dyslipidemia after liver transplantation, changing lifestyle and dietary habits and adjusting the immunosuppressive regimen are preferred. Changes in lifestyle and dietary habits include quitting smoking, limiting salt and alcohol consumption, reducing the intake of saturated fatty acids and cholesterol, choosing foods that can reduce LDL-C, such as phytosterols (2 g/d) and soluble fibers (10-25 g/d), reducing weight (by 5%-10% for recipients who are overweight or obese), and regular physical exercise, including adequate medium-intensity exercise to consume at least 836.8 kJ of calories every day. Of all the immunosuppressive agents, MPA represented by MMF has no impact on blood lipids. Some studies have shown that withdrawal or reduction of CNIs on the basis of MMF will lead to decreases of TC and TG. The dyslipidemia induced by the immunosuppressive regimen of MMF combined with TAC is significantly lower than that induced by mTORi combined with TAC. Refractory dyslipidemia (currently not clearly defined) is generally considered to include the following situations: severe dyslipidemia, such as severe elevation of TG level (≥ 5.65 mmol/L or 500 mg/dL) or (and) LDL level (≥ 4.92 mmol/L or 190 mg/dL) or those who still have elevated TG or LDL level after regular lipid-lowering therapy. For refractory dyslipidemia or dyslipidemia confirmed to be caused by immunosuppressive agents, adjusting the immunosuppressive regimen, such as discontinuing mTORi, replacing CsA with TAC, or using the regimen of reduced CNIs combined with MMF, should be considered.

If blood lipid levels cannot be controlled by changing dietary habits, exercising more, and adjusting the immunosuppressive regimen, drugs should be used. Statins are the preferred treatment for hypercholesterolemia, but adverse effects, especially potential hepatotoxicity and myopathy, should be guarded against. Most statins (except hydrophilic statins: pravastatin, fluvastatin) and CNIs are metabolized by cytochrome P450. Therefore, during the use of statins, it is necessary to monitor the plasma concentration of immunosuppressive agents and adjust the dose timely. Simvastatin and CNIs have an obvious interaction in the metabolic process, so simvastatin is not recommended in liver transplant recipients. For hypertriglyceridemia recipients with a normal cholesterol level, fish oil is preferred. If its effect is still unsatisfactory, xylolheptanoic acid or fenofibrate can be added. For recipients with normal liver function, lipid-regulating drugs can be continued. However, such drugs should be discontinued for recipients with liver enzymes over three times higher than the normal values, and liver function should be monitored to identify the causes of abnormal liver function before deciding whether to use lipid-lowering drugs.

Recommendation 8: The blood lipid target after liver transplantation is: LDL-C < 2.59 mmol/L (100 mg/dL). For recipients with cardiovascular risk factors, it is LDL-C < 1.8 mmol/L (70 mg/dL).

Recommendation 9: For liver transplant recipients with dyslipidemia, reducing and withdrawing glucocorticoids should be considered; mTORi should be carefully used and blood lipid indicators should be monitored closely. For refractory dyslipidemia or dyslipidemia caused by immunosuppressive agents, the immunosuppressive regimen should be adjusted; physicians can consider discontinuing mTORi, converting CsA to...
TAC, or adopting the regimen of reduced CNIs combined with MPA.

Recommendation 10: Statins are the preferred treatment for hypercholesterolemia. Liver function, creatine kinase, and concentration of immunosuppressive agents should be closely monitored before and after using statins.

Recommendation 11: Fish oil is the preferred treatment for hypertriglyceridemia. Xylene heptanoic acid or fenofibrate can be added if fish oil fails to achieve a satisfactory effect.

**Prophylaxis and treatment of hyperuricemia**

Chinese Nephrologist Association Clinical Practice Guidelines for the Diagnosis and Treatment of Hyperuricemia in Patients with Kidney Diseases 2017 points out that hyperuricemia (HUA) refers to two fasting serum uric acid (SUA) measurements on different days being higher than 420 μmol/L for men and postmenopausal women and higher than 360 μmol/L for non-menopausal women under normal urine dietary conditions. The incidence of hyperuricemia after liver transplantation ranges from 14% to 53%.[29] Hyperuricemia can cause gout, uric acid stones, and renal injury and is closely related to T2DM and hypertension, cardiovascular disease, chronic kidney disease, etc.[30,31] Chronic nephropathy caused by hyperuricemia after liver transplantation is one of its main hazards[32]. The hyperuricemia control target: for patients with hyperuricemia complicated with cardiovascular risk and cardiovascular disease, SUA should be lower than 360 μmol/L; for patients with gout, SUA should be lower than 300 μmol/L.[33]

Post-liver transplant hyperuricemia may be related to immunosuppressive agents, HUA history, and diuretics[34]. It has been confirmed that hyperuricemia is associated with immunosuppressive agents, mainly CNIs (CsA and TAC), which can decrease uric acid excretion by reducing glomerular filtration rate and increasing the renal tubular reabsorption of uric acid[35,36]. Some studies reported that the incidence of HUA in recipients treated with CsA after transplantation was much higher than those receiving TAC[37]. However, some other reports showed no significant difference in new-onset HUA between CsA and TAC[38]. The general treatment for hyperuricemia after liver transplantation includes changing the unhealthy lifestyle, such as adopting the low purine diet, drinking more water, alkalinizing urine properly, and exercising more. In addition, screening for related complications, cooperating with specialists, and actively managing metabolic and cardiovascular risk factors related to the elevation of the SUA level should be taken into consideration[39]. Drugs that can increase SUA should be avoided as much as possible. Some reports showed that SUA level decreased by combining MMF with reduced CNIs[39], converting CNIs to mTORi[40], or converting TAC in general dosage form to TAC in sustained-release dosage form[40].

If the general treatment fails to control hyperuricemia effectively, drugs should be used. According to the classification and diagnosis criteria of hyperuricemia, drugs that promote uric acid excretion, such as benzbromarone, fenofibrate, losartan, and those drugs that can inhibit uric acid production such as allopurinol, febuxostat and topiroxostat, can be selected[40]. These drugs can effectively reduce SUA level, with no impact on the concentration of immunosuppressive agents reported[41-43]. Allopurinol and benzbromarone should be used cautiously in recipients with severe renal insufficiency. Instead, febuxostat or topiroxostat can be used when renal insufficiency exists. However, when liver function is severely impaired, febuxostat or topiroxostat should be used cautiously. Antihypertensive and lipid-lowering drugs, losartan and fenofibrate, also can decrease uric acid, and they are preferred for liver transplantation recipients with hypertension or dyslipidemia[47].

As only observational studies have shown that both SUA and serum creatinine decreased with the uric acid-lowering therapy[44], additional studies are needed to confirm whether uric acid-lowering therapy can effectively improve the renal function of liver transplant recipients and reduce the mortality.

Recommendation 12: The long-term control target of SUA after liver transplantation is as follows: for patients with hyperuricemia complicated with cardiovascular risk factors and cardiovascular disease, SUA should be lower than 360 μmol/L; for patients with gout, SUA should be lower than 300 μmol/L.

Recommendation 13: Reduction or even withdrawal of CNIs after liver transplantation combined with MPA or mTORi can contribute to the reduction of SUA.

Recommendation 14: Drugs that promote uric acid excretion or inhibit uric acid production should be selected according to the classification and diagnostic criteria of HUA. Recipients with severe renal insufficiency can be treated with febuxostat or topiroxostat, and benzbromarone can be used when liver function is severely
impaired. Losartan and fenofibrate can be used for recipients with hypertension and for those with dyslipidemia, respectively.

**Prophylaxis and treatment of obesity**

The World Health Organization defines obesity as body mass index (BMI) ≥ 30 kg/m², and it is further classified into type I obesity (BMI 30-34.9 kg/m²), type II obesity (BMI 34.9-40 kg/m²), and type III obesity (BMI ≥ 40 kg/m²)⁶⁶; when BMI is above 40 kg/m², it is pathological obesity⁶⁷. New-onset obesity after liver transplantation is defined as BMI ≥ 30 kg/m² during the follow-up after transplantation. Studies showed that the incidence of obesity at 1 year and 3 years post transplantation in adult recipients was 23.7% and 30.6% respectively, while it was 19% and 18%, respectively, in pediatric recipients⁶⁸. Obesity is closely associated with the outcome of liver transplant recipients, and overall decreases in obese recipients⁶⁹. Moreover, new-onset obesity in liver transplant recipients is closely related to cardiovascular events, infections, and respiratory failure⁷⁰. BMI after liver transplantation should be controlled below 30 kg/m² and within 25 kg/m² as far as possible.

Weight gain and subsequent obesity are driven by a complex interplay of genetic, physiological, behavioral, and environmental factors⁷¹. Obesity before transplantation is a very high risk factor for obesity after transplantation⁷². Other risk factors include genetic and psychological factors (such as depression), age, sex, race, dietary habits, exercise habits, immunosuppressive agents, etc. For liver transplant recipients treated with immunosuppressive agents, the dose and duration of glucocorticoids are the main causes of weight gain⁷³. The standard-dose CNIs cause more weight gain than reduced CNIs combined with MMF or mTOR. It has been reported that TAC users are more likely to gain weight 1 year after liver transplantation than CSA users⁷⁴.

Obese recipients can control BMI below 25 kg/m² by changing their lifestyle (diet/exercise) and medication and by undergoing surgery when appropriate. Reduction or discontinuation of glucocorticoids is recommended for high-risk recipients, and early conversion of TAC to CsA may also be considered. In addition to improving lifestyle and adjusting immunosuppressive agents, drugs and weight-loss surgery should be introduced in the early post-transplant period when necessary. Drugs for obesity can be classified into non-central weight-loss drugs (with orlistat as the representative drug), central weight-loss drugs (sympathomimetic drugs, such as phentermine; 5-hydroxytryptamine drugs, such as lorcaserin), and hypoglycemic drugs (such as metformin, liraglutide). For liver transplant recipients with refractory obesity, it is difficult to achieve significant results through diet, exercise, and drugs. In these patients, weight-loss surgery has become the main treatment regimen, including Roux-en-Y gastric bypass surgery, gastric sleeve resection, and biliary-pancreatic shunt surgery. In addition, endoscopic therapy can limit the contact between food intake and gastrointestinal mucosa, thus limiting absorption and achieving weight loss. However, neither surgical nor endoscopic therapy has become a treatment standard for liver transplant recipients. The standard-dose CNIs cause more weight gain than reduced CNIs combined with MMF or mTOR. It has been reported that TAC users are more likely to gain weight 1 year after liver transplantation than CSA users. Obese recipients who have failed to respond to behavioral therapy and drug therapy, surgical treatment may be considered.

**MONITORING OF METABOLIC DISEASE IN LIVER TRANSPLANT RECIPIENTS**

For liver transplant recipients, monitoring of metabolic disease should be the focus. The immunosuppressive regimen should be adjusted timely according to disease situation. It should be evaluated at least every 6 mo to reduce the long-term toxicity of drugs, and the possible secondary cardiovascular events and renal impairment. Glucose, blood pressure, lipid, serum uric acid, and BMI should be taken as routine follow-up monitoring items after liver transplantation. Metabolic disease monitoring in liver transplant recipients is not substantially different from that in non-transplant patients. For diabetic recipients, lycosylated hemoglobin is the gold standard for long-term blood glucose control, while self-blood glucose monitoring is the primary measurement. The combination of glycosylated hemoglobin screening and oral glucose tolerance test is an ideal method with both examination and diagnostic efficiency. Family blood pressure measurement is also encouraged for hypertensive
recipients; LDL-C, TG, TC, and serum uric acid are the basic monitoring items for liver transplant recipients with dyslipidemia and hyperuricemia\(^{15,81}\); long-term monitoring of body weight after liver transplantation is required.

For liver transplant recipients with diabetes mellitus, hypertension, dyslipidemia, hyperuricemia, or obesity, besides the basic monitoring items mentioned above, electrocardiogram, 24-h ambulatory blood pressure, coronary computed tomography angiography, B-mode ultrasonography of the carotid artery, urinary protein, ophthalmoscopy, bilateral renal ultrasound, joint X-ray or computed tomography, and other examinations should be performed (Table 4). Through these examinations on target organs, cardiovascular and cerebrovascular diseases, chronic kidney disease, retinopathy, gouty arthritis, and other diseases that may be secondary to metabolic disease can be promptly detected and diagnosed, so as to improve the long-term survival of liver transplant recipients. The efficacy of the treatments on metabolic disease should be evaluated every 3 mo\(^{82}\). Standardized monitoring needs the attention of transplantation physicians and the cooperation of recipients.

Recommendation 16: For long-term survival of liver transplantation, attention should be paid to monitoring of metabolic disease.

Recommendation 17: The immunosuppressive regimen should be evaluated at least once every 6 mo in order to reduce long-term toxicity and should be adjusted as needed.

Recommendation 18: Blood pressure, lipid, glucose, serum uric acid, and BMI should be monitored every 3 mo in the first year after liver transplantation, and every year after that, and the efficacy of the treatment for metabolic disease should be evaluated every 3 mo.
### Table 4 Monitoring of metabolic disease after liver transplantation

| Metabolic disease | Monitoring indicator | Target | Other related examination items |
|-------------------|----------------------|--------|---------------------------------|
| Diabetes mellitus | FPG, HbA1c, and OGTT | FPG < 6.7 mmol/L, peak value < 8.88 mmol/L or HbA1c < 7% | Urinary protein, ophthalmoscopy, B-mode ultrasonography of the carotid artery, and coronary CT angiography |
| Hypertension      | Arterial pressure    | Arterial pressure < 130/80 mmHg | 24-h ambulatory blood pressure, ECG, coronary CT angiography, urinalysis, ophthalmoscopy |
| Dyslipidemia      | LDL-C, TC, TG        | LDL-C < 100 mg/dL; patients with cardiovascular risk factors, LDL-C < 70 mg/dL | ECG, B-mode ultrasonography of the carotid artery and coronary CT angiography |
| Hyperuricemia     | SUA                  | SUA < 360 μmol/L; patients with gout attack, SUA < 300 μmol/L | Urinary protein, serum creatinine, glomerular filtration rate, bilateral renal ultrasound, joint ultrasound, joint X-ray or CT |
| Obesity           | BMI                  | BMI < 25 kg/m² | Coronary CT angiography and B-mode ultrasonography of the carotid artery |

CT: Computed tomography; ECG: Electrocardiogram; SUA: Serum uric acid; BMI: Body mass index; LDL-C: Low density lipoprotein cholesterol; TC: Cholesterol; TG: Triglycerides; FPG: Fasting plasma glucose; HbA1c: Glycated hemoglobin; OGTT: Oral glucose tolerance test.

### REFERENCES

1. Report on Medical Quality of Liver Transplantation in China in 2018. Available from: http://www.csrtk.org/pg/statisticalReport/statisticalReport
2. Kwong A, Kim WR, Lake JR, Smith JM, Schlapt D, Skeans MA, Noreen SM, Foutz J, Miller E, Snyder JJ, Israni AK, Kasiske BL. OPTN/SRTR 2018 Annual Data Report: Liver. Am J Transplant 2020; 20 Suppl 1: 193-299 [PMID: 3189413 DOI: 10.1111/j.1600-6143.2012.04077.x]
3. Jenessen T, Hartmann A. Post-transplant diabetes mellitus in patients with solid organ transplants. Nat Rev Endocrinol 2019;15: 172-188 [PMID: 30622369 DOI: 10.1038/s41574-018-0137-7]
4. Gojowy D, Adamczak M, Dudaicz S, Gazda M, Karkowski H, Wieczek A. High Frequency of Arterial Hypertension in Patients After Liver Transplantation. Transplant Proc 2016; 48: 1721-1724 [PMID: 27496479 DOI: 10.1016/j.transproceed.2015.11.043]
5. Chinese Society of Organ Transplantation. Standard for the Management of Blood Lipid in Chinese Solid Organ Transplant Recipients (2019 Edition). Qiguan Zhiyi 2019; 10: 101-111
6. Neal DA, Tom BD, Gimson AE, Gibbs P, Alexander GJ. Hyperuricemia, gout, and renal function after liver transplantation. Transplantation 2001; 72: 1689-1691 [PMID: 11726834 DOI: 10.1097/00007890-2001111270-00021]
7. Longenecker JC, Waheed S, Bandag K, Murakami CA, McMahon BA, Gelber AC, Atta MG. Hyperuricemia after orthotopic liver transplantation: divergent associations with progression of renal disease, incident end-stage renal disease, and mortality. BMC Nephrol 2017; 18: 103 [PMID: 28347282 DOI: 10.1186/s12882-017-0518-5]
8. Chen CY, Jiang WT, Zhang L, Tian DZ, Guo QJ, Li JJ. Long-term Post-liver-transplantation Hyperuricemia and Treatment of Renal Function Damage: Report of 27 Adult Cases. Zhonghua Qiguan Zhiyi Zazhi 2016; 37: 411-414
9. Rao WP, Niu YJ, Wang HY, Xu C. The Incidence and Risk Factors of Hyperuricemia after Liver Transplantation: A Single-center Retrospective Study. Zhonghua Niefei Min Waike Zazhi 2015; 6: 493-496
10. Rezende Anastacio L, Garcia Ferreira L, Costa Liboredo J, de Sena Ribeiro H, Soares Lima A, Garcia Vilela E, Correia MI. Overweight, obesity and weight gain up to three years after liver transplantation. Nutr Hosp 2012; 27: 1351-1356 [PMID: 23165585 DOI: 10.3305/nh.2012.27.4.5768]
11. Sundaram SS, Alonso EM, Zeitzer P, Yin W, Anand R, SLIIT Research Group. Obesity after pediatric liver transplantation: prevalence and risk factors. J Pediatr Gastroenterol Nutr 2012; 55: 657-662 [PMID: 22744195 DOI: 10.1097/MPG.0b013e318266243c]
12. Davis BC, Shadab Siddiqui M. Liver Transplantation: the Role of the Metabolic Syndrome. Curr Treat Options Gastroenterol 2017; 15: 316-331 [PMID: 28482575 DOI: 10.1007/s11938-017-0325-z]
13. Li XY, Huang L, Zhu JY. Complications in patients surviving over ten years after liver transplantation. Zhonghua Qiguan Zhiyi Zazhi 2019; 18: 347-351 [DOI: 10.3760/cma.j.issn.1671-7368.2019.04.011]
14. Jiménez-Pérez M, González-Grande R, Omonte Guzmán E, Amo Trillo V, Rodrigo López JM. Metabolic complications in liver transplant recipients. World J Gastroenterol 2016; 22: 6416-6423 [PMID: 27605877 DOI: 10.3748/wjg.v22.i28.6416]
15. Lacey MR, Terrault N, Ojo L, Hay JE, Neuberger J, Blumberg E, Teperman L.W. Long-term management of the successful adult liver transplant: 2012 practice guideline for the American Association for the Study of Liver Diseases and the American Society of Transplantation. Liver Transplant 2013; 19: 3-26 [PMID: 23281277 DOI: 10.1002/lt.23566]
16. Parekh J, Corley DA, Feng S. Diabetes, hypertension and hyperlipidemia: prevalence over time and impact on long-term survival after liver transplantation. Am J Transplant 2012; 12: 2181-2187 [PMID: 22548965 DOI: 10.1111/j.1600-6143.2012.04077.x]
17. Li XY, Zhu JY, Huang L, Li GM, Leng XS. Metabolic Syndrome in Liver Transplant Recipients: Prevalence and Risk Factors. Zhonghua Putong Waike Zazhi 2012; 27: 8-11 [DOI: 10.3760/cma.j.issn.1007-631X.2012.01.004]
Shen T et al. Guidelines on management of metabolic disease in liver transplantation recipients

Kim WR, Lake JR, Smith JM, Schladt DP, Skeans MA, Noreen SM, Robinson AM, Miller E, Snyder JJ, Israni AK, Kasiskie BL. OPTN/SRTR 2017 Annual Data Report: Liver. Am J Transplant 2019; 19 Suppl 2: 184-283 [PMID: 30811890 DOI: 10.1111/ajt.15276]

Watt KD. Charlton MR. Metabolic syndrome and liver transplantation: a review and guide to management. J Hepatol 2010; 53: 199-206 [PMID: 20451282 DOI: 10.1016/j.jhep.2010.01.040]

Lalish I, Braun M, Mor E, Sulkes J, Harif Y, Ben Ari Z. Metabolic syndrome in liver transplant recipients: prevalence, risk factors, and association with cardiovascular events. Liver Transpl 2011; 17: 15-22 [PMID: 21254340 DOI: 10.1002/hep.22198]

De Simone P, Carrafi, Coletti L, Ghinolfi D, Petruccelli S, Precia S, Campani D, Marchetti P, Filippini F. Everolimus vs Mycophenolate Mofetil in Combination With Tacrolimus: A Propensity Score-matched Analysis in Liver Transplantation. Transplant Proc 2018; 50: 3615-3620 [PMID: 30577246 DOI: 10.1016/j.transproced.2018.07.011]

American Diabetes Association. 2. Classification and Diagnosis of Diabetes: Standards of Medical Care in Diabetes-2019. Diabetes Care 2019; 42: S13-S28 [PMID: 30559228 DOI: 10.2337/dc19-s002]

American Diabetes Association. 2. Classification and Diagnosis of Diabetes. Standards of Medical Care in Diabetes-2018. Diabetes Care 2018; 41: S13-S27 [PMID: 29222373 DOI: 10.2337/dc18-s002]

Neuberger JM, Bechstein WO, Kuypers DR, Burra P, Citterio F, De Geest S, Davovux C, Jardine AG, Kamar N, Krämer BK, Metselaar HJ, Nevens F, Pierreje R, Rodríguez-Perálvarez ML, Samuel D, Schneeberger S, Serón D, Truncelka P, Qinsme G, van Gelder T. Practical Recommendations for Long-term Management of Modifiable Risks in Kidney and Liver Transplant Recipients: A Guidance Report and Clinical Checklist by the Consensus on Managing Modifiable Risk in Transplantation (COMMIT). Transplantation 2017; 101: S1-S56 [PMID: 28328734 DOI: 10.1097/TP.0000000000001651]

Charlton M, Levitsky J, Abel Q, Grady J, Hirnbich J, Rincilla M, Fung J, Qualhierl M, Thomason R, Burra P, Little JC, Berenguer M, Shaked A, Tropper J, Roberts J, Rodriguez-Davalos M, Rela M, Pomfret E, Heyrend C, Gallegos-Orozco J, Saliba F. International Liver Transplantation Society Consensus Statement on Immunosuppression in Liver Transplant Recipients. Transplantation 2018; 102: 727-743 [PMID: 29485508 DOI: 10.1097/TP.0000000000002147]

Organ Transplantation Branch, Chinese Medical Doctor Association; Organ Transplantation Group, Chinese Society of Sugery, Chinese Medical Association; Liver Transplantation Group, Chinese Society of Organ Transplantation. Expert Consensus on Management of Metabolic Disease in Chinese Liver Transplant Recipients (2015 Edition). Zhonghua Yi Zhi Zazhi (Electronic Version) 2015; 9: 103-107

Grancini V, Resi V, Palmieri E, Pugliese G, Orsi E. Management of diabetes mellitus in patients undergoing liver transplantation. Pharmacol Res 2019; 141: 556-573 [PMID: 30690071 DOI: 10.1016/j.phrs.2019.01.042]

Song JH, Li M, Yan LN, Yang JY, Yang X. Higher tacrolimus blood concentration is related to increased risk of post-transplantation diabetes mellitus after living donor liver transplantation. Int J Surg 2018; 51: 17-23 [PMID: 29366011 DOI: 10.1016/j.ijsu.2017.12.037]

Li DW, Lu TF, Hua XW, Dai HJ, Cui XL, Zhang JJ, Xia Q. Risk factors for new onset diabetes mellitus after liver transplantation: A meta-analysis. World J Gastroenterol 2015; 21: 6329-6340 [PMID: 26034369 DOI: 10.3748/wjg.v21.i20.6329]

Yagi S, Kaido T, Iida T, Yoshizawa A, Okajima H, Uemoto S. New-onset diabetes mellitus after living-donor liver transplantation: association with graft synthetic function. Surg Today 2017; 47: 733-742 [PMID: 27837295 DOI: 10.1007/s00268-016-1444-z]

Chen C, Fang BX, Yu SF, Liu JM, Liu YX, Zhou L, Yu J, Zheng SS. Association between ADIPOQ gene polymorphisms and the risk of new-onset diabetes mellitus after liver transplantation. Hepatobiliary Pancreat Dis Int 2017; 16: 602-609 [PMID: 29291779 DOI: 10.1016/j.hbp.2017.06.009]

Zhang T, Liu Y, Hu Y, Zhang X, Zhong L, Fan J, Peng Z. Association of donor and recipient SUMO4 rs237025 genetic variant with new-onset diabetes mellitus after liver transplantation in a Chinese population. Gene 2017; 467: 428-433 [PMID: 26889037 DOI: 10.1016/j.gene.2017.06.060]

Gillis KA, Patel RK, Jardine AG. Cardiovascular complications after transplantation: treatment options in solid organ recipients. Transplant Rev (Orlando) 2014; 28: 47-55 [PMID: 24412041 DOI: 10.1016/j.trcr.2013.12.001]

Kato T, Gaynor JJ, Yoshida H, Montalvano M, Takahashi H, Prysoupolos N, Nishida S, Moon J, Selvaggi G, Levi D, Ruiz P, Schiff E, Tzakis A. Randomized trial of steroid-free induction versus corticosteroid maintenance among orthotopic liver transplant recipients with hepatitis C virus: impact on hepatic fibrosis progression at one year. Transplantation 2007; 84: 829-835 [PMID: 17984834 DOI: 10.1097/01.TP.0000282914.20578.7b]

Kim YK, Lee KW, Kim SH, Cho SY, Han SS, Park SI. Early steroid withdrawal regimen prevents new-onset diabetes mellitus in old-age recipients after living donor liver transplantation. World J Surg 2012; 36: 2443-2448 [PMID: 22674089 DOI: 10.1007/s00268-012-1661-6]

Lorho R, Hardwigsen J, Dumortier J, Pageaux GP, Durand F, Bizollon T, Blanc AS, Di Giambattista F, Davovux C. Regression of new-onset diabetes mellitus after conversion from tacrolimus to cyclosporine in liver transplant patients: results of a pilot study. Clin Res Hepatol Gastroenterol 2011; 35: 482-488 [PMID: 21530445 DOI: 10.1016/j.clinre.2011.03.008]

Herrero JJ, Quiroga J, Sangro B, Pardo F, Rotellar F, Cifuentes JA, Prieto J. Conversion from calcineurin inhibitors to mycophenolate mofetil in liver transplant recipients with diabetes mellitus. Transplant Proc 2003; 35: 1877-1879 [PMID: 12962832 DOI: 10.1016/S0041-1345(03)00544-4]

Kidney Disease: Improving Global Outcomes (KDIGO) Transplant Work Group. KDIGO clinical practice guideline for the care of kidney transplant recipients. Am J Transplant 2009; 9 Suppl 3: S1-155 [PMID: 19845597 DOI: 10.1111/j.1600-6143.2009.02834.x]

Association AD. 1. Improving Care and Promoting Health in Populations: Standards of Medical Care in Diabetes-2020. Diabetes Care 2020; 43: S7-S13 [PMID: 31862744 DOI: 10.2337/dci20-S001]

Jenssen H, Hartmann A. Prevention and management of transplant-associated diabetes. Expert Opin Pharmacother 2011; 12: 2641-2655 [PMID: 22047007 DOI: 10.1517/14656556.2011.628936]
41 Chinese Society of Organ Transplantation. Standard for the Diagnosis and Treatment of Post-transplant Diabetes Mellitus in Chinese Patients (2019 Edition). Zhonghua Yi Yi Zazhi 2019; 10: 1-9 [DOI: 10.3969/j.issn.2095-5312.2019.03.002]

42 Neal DA, Brown MJ, Wilkinson IB, Alexander GJ. Mechanisms of hypertension after liver transplantation. Transplantation 2005; 79: 935-940 [PMID: 15849546 DOI: 10.1097/01.tp.0000158738.00927.67]

43 Fujinaga K, Usui M, Yamamoto N, Ishikawa E, Nakatani A, Kishiwada M, Mizuno S, Sakurai H, Tabata M, Isaji S. Hypertension and hepatitis C virus infection are strong risk factors for developing late renal dysfunction after liver donor liver transplantation: significance of renal biopsy. Transplant Proc 2014; 46: 578-580 [PMID: 24767353 DOI: 10.1016/j.transproceed.2013.11.103]

44 Tong MS, Chai HT, Liu WH, Chen CL, Fu M, Lin YH, Lin CC, Chen SM, Hang CL. Prevalence of hypertension after living-donor liver transplantation: a prospective study. Transplant Proc 2015; 47: 445-450 [PMID: 25759338 DOI: 10.1016/j.transproceed.2015.09.009]

45 Chinese Society of Organ Transplantation. Standard for the Diagnosis and Treatment of Hypertension after Solid Organ Transplantation in Chinese Patients (2019 Edition). Zhonghua Yi Yi Zazhi 2019; 10: 112-121 [DOI: 10.3969/j.issn.1674-7445.2019.02.002]

46 Thoene LB, Rostvedt AA, Pommegard HC, Rasmussen A. Risk factors for metabolic syndrome after liver transplantation: A systematic review and meta-analysis. Transplant Rev (Orlando) 2018; 32: 69-77 [PMID: 28500138 DOI: 10.1016/j.trre.2017.03.004]

47 Garcia-Pajares F, Peláez-Herrero I, Sánchez-Ocaña R, Torres-Yuste R, Cimavilla-Román M, Carbajo-López A, Almohallá-Alvarez C, Pérez-Saborido B, Muñoz-Concejero E, González-Sagrado M, Caro-Patoán A, Sánchez-Antigüo G. Metabolic Syndrome After Liver Transplantation: Five-Year Prevalence and Risk Factors. Transplant Proc 2016; 48: 3010-3012 [PMID: 27932133 DOI: 10.1016/j.transproceed.2016.07.038]

48 Anastácio LR, Ribeiro Hde S, Ferreira LG, Lima AS, Vilela EG, Toulsen Davisson Correia MI. Incidence and risk factors for diabetes, hypertension and obesity after liver transplantation. Nutr Hosp 2013; 28: 643-648 [PMID: 23840863 DOI: 10.3305/eh.2013.28.3.6193]

49 Racklin JM, Rosen HR, Corless CL, Oyaei AJ. Tacrolimus is associated with a lower incidence of cardiovascular complications in liver transplant recipients. Transplantation proceedings 2002; 34: 1557-1558 [PMID: 12176483 DOI: 10.1016/s0041-1345(02)03020-3]

50 Guckelberger O. Long-term medical comorbidities and their management: hypertension/cardiovascular disease. Liver Transpl 2009; 15 Suppl 2: S75-S78 [PMID: 19877022 DOI: 10.1002/lt.21903]

51 D’Avola D, Cuervas-Mons V, Martí J, Ortiz de Urbina J, Lladò L, Giménez B, Otero E, Suárez F, Rodrigo JM, Gómez MA, Fraga E, López P, Serrano MT, Rios A, Fábrega E, Herrero J. Cardiovascular morbidity and mortality after liver transplantation: The protective role of mycophenolate mofetil. Liver Transplant 2017; 23: 498-509 [PMID: 28360394 DOI: 10.1002/lt.24738]

52 Gonwa T, Mendez R, Yang HC, Weinstein S, Jensik S, Steinberg S. Prograf Study Group. Randomized trial of tacrolimus in combination with sirolimus or mycophenolate mofetil in kidney transplantation: results at 6 months. Transplantation 2003; 75: 1213-1220 [PMID: 12717205 DOI: 10.1097/01.tp.0000062837.99400.60]

53 Wei Q, Gao F, Zhuang R, Ling Q, Ke Q, Wu J, Shen T, Zhang M, Zhang M, Xu X, Zheng S. A national report from China Liver Transplant Registry: steroid avoidance after liver transplantation for hepatocellular carcinoma. Chin J Cancer Res 2017; 29: 426-437 [PMID: 29142462 DOI: 10.21147/j.issn.1399-0012.2017.05.07]

54 Barnard A, Konyon P, Saab S. Medical Management of Metabolic Complications of Liver Transplant Recipients. Gastroenterol Hepatol (N Y) 2016; 12: 601-608 [PMID: 27917074]

55 Sohn AJ, Jeon H, Ahn J. Primary care of the liver transplant recipient. Prim Care 2011; 38: 499-514; ix [PMID: 21870294 DOI: 10.1016/j.pop.2011.05.006]

56 Warden BA, Duell PB. Management of dyslipidemia in adult solid organ transplant recipients. J Clin Lipidol 2019; 13: 231-245 [PMID: 30928441 DOI: 10.1016/j.jcllip.2019.01.011]

57 Orlandi G, Biascioni L, Cardillo A, Iaria G, De Liguori Carino N, De Luca L, Ielpo B, Tariciotti L, Angelico M, Tisonne G. Switch to 1.5 grams MMF monotherapy for CNI-related toxicity in liver transplantation is safe and improves renal function, dyslipidemia, and hypertension. Liver Transpl 2007; 13: 46-54 [PMID: 17154392 DOI: 10.1002/hep.20926]

58 Shen WF. Refractory Cardiovascular Diseases. Shanghai Scientific Technical Publishers, 2007

59 Chinese Nephrologist Association, Chinese Medical Association. Guidelines for the Diagnosis and Treatment of Hyperuricemia in Renal Diseases in China (2017 edition). Zhonghua Nei Ke Za Zhi 2017; 46: 1927-1936 [DOI: 10.3760/cma.j.issn.0376-2491.2017.25.003]

60 Chinese Society of Organ Transplantation. Technical Specification for Diagnosis and Treatment of Hyperuricemia after Renal Transplantation in China (2019 Edition). Zhonghua Yi Yi Zazhi 2019; 10: 10-15 [DOI: 10.3969/j.issn.1674-7445.2019.01.002]

61 Laine J, Holmberg C. Mechanisms of hyperuricemia in cyclosporine-treated renal transplant children. Nephron 1996; 74: 318-323 [PMID: 8893148 DOI: 10.1159/000138928]

62 Tumgor G, Arikan C, Kiliç M, Aydogdu S. Frequency of hyperuricemia and effect of calciuminhibitors on serum uric acid levels in liver transplanted children. Pediatr Transplant 2006; 10: 665-668 [PMID: 16911488 DOI: 10.1111/j.1399-3046.2006.00556.x]

63 Balheiro J, Almeida M, Fonseca I, Martins LS, Pedroso S, Dias L, Henriques AC, Cabrita A. Hyperuricemia in adult renal allograft recipients: prevalence and predictors. Transplantation 2012; 44: 2369-2372 [PMID: 23026595 DOI: 10.1016/j.transproceed.2012.07.033]

64 Kaynar K, Erosoz A, Alyazicioglu R, Urun A, Ulusoy S, Al S, Ozkan G, Cansuz M. Is there any way to protect from tacrolimus-induced renal and pancreas injury? Clin Transplant 2012; 26: 722-728 [PMID: 22428934 DOI: 10.1111/j.1399-0012.2012.01603.x]

65 Kanbay M, Akcay A, Huddam B, Usluogullari CA, Arat Z, Ozdemir FN, Haberal M. Influence of cyclosporine and tacrolimus on serum uric acid levels in stable kidney transplant recipients. Transplant Proc 2005; 37: 3119-3120 [PMID: 16213325 DOI: 10.1016/j.transproceed.2005.08.042]
## Shen T et al. Guidelines on management of metabolic disease in liver transplantation recipients

| Page | Reference |
|------|-----------|
| 66   | Moreno Planas JM, Cuervas-Mons Martinez V, Rubio Gonzalez E, Gomez Cruz A, Lopez-Monclus J, Sánchez-Turrion V, Lucena Poza JL, Jimenez Garrido M, Milan J. Mycophenolate mofetil can be used as monotherapy late after liver transplantation. *Am J Transplant* 2004; 4: 1650-1655 [PMID: 15367220 DOI: 10.1111/j.1600-6143.2004.00556.x] |
| 67   | Klintmalm GB, Nashan B. The Role of mTOR Inhibitors in Liver Transplantation: Reviewing the Evidence. *J Transplant* 2014; 2014: 845438 [PMID: 24719752 DOI: 10.1155/2014/845438] |
| 68   | Sofue T, Inui M, Hara T, Nishijima Y, Moriwaki K, Hayashida Y, Ueda N, Nishiyama A, Kakemi Y, Kohno M. Efficacy and safety of febuxostat in the treatment of hyperuricemia in stable kidney transplant recipients. *Drug Des Devel Ther* 2014; 8: 245-253 [PMID: 24660205 DOI: 10.2147/DDDT.S56597] |
| 70   | Obesity: preventing and managing the global epidemic. Report of a WHO consultation. *World Health Organ Tech Rep Ser* 2000; 894: i-xii, 1-253 [PMID: 11234459] |
| 71   | Beckmann S, Denhaerynck K, Stampf S, Saiagi-Morgui N, Binet I, Koller M, Boey E, De Geest S; Psychosocial Interest Group; Swiss Transplant Cohort Study. New-onset obesity after liver transplantation-outcomes and risk factors: the Swiss Transplant Cohort Study. *Transpl Int* 2018; 31: 1254-1267 [PMID: 29984844 DOI: 10.1111/tri.13308] |
| 72   | Richards J, Gunson B, Johnson J, Neuberger J. Weight gain and obesity after liver transplantation. *Transpl Int* 2005; 18: 463-466 [PMID: 15773968 DOI: 10.1111/j.1432-2277.2004.00667.x] |
| 73   | Saab S, Lalehari D, Pruthi P, Alper T, Tong MJ. The impact of obesity on patient survival in liver transplant recipients: a meta-analysis. *Liver Int* 2015; 35: 164-170 [PMID: 24313970 DOI: 10.1111/liv.12431] |
| 74   | Speangler EK, O’Leary JG, Te HS, Rogal S, Pillai AA, Al-Osaimi A, Desai A, Fleming JN, Ganger D, Seetharam A, Tsoulfas G, Montenovo M, Lai JC. Liver Transplantation in the Obese Cirrhotic Patient. *Transplantation* 2017; 101: 2288-2296 [PMID: 28930104 DOI: 10.1097/TP.0000000000001794] |
| 75   | Bray GA, Frühbeck G, Ryan DH, Wilding JP. Management of obesity. *Lancer* 2016; 387: 1947-1956 [PMID: 26886660 DOI: 10.1016/S0140-6736(16)30271-3] |
| 76   | Lim LG, Cheng CL, Wee A, Lim SG, Lee YM, Sutedja DS, Da Costa M, Prabhakaran K, Wai CT. Prevalence and clinical associations of posttransplant fatty liver disease. *Liver Int* 2007; 27: 76-80 [PMID: 17241384 DOI: 10.1111/j.1478-3231.2006.01396.x] |
| 77   | Everhart JE, Lombardero M, Lake JR, Wiesner RH, Zetterman RK, Hoofnagle JH. Weight change and obesity after liver transplantation: incidence and risk factors. *Liver Transpl Surg* 1998; 4: 285-296 [PMID: 9649642 DOI: 10.1002/lts.490040402] |
| 78   | Charlton M, Rinella M, Patel D, McCague K, Heimbach J, Watt K. Everolimus Is Associated With Less Weight Gain Than Tacrolimus 2 Years After Liver Transplantation: Results of a Randomized Multicenter Study. *Transplantation* 2017; 101: 2873-2882 [PMID: 28817434 DOI: 10.1097/TP.0000000000001913] |
| 79   | Chen H, Shan S, Wang Y, Shen ZY. Research Progress in Obesity after Liver Transplantation. *Zhongguo Jijiufusu Yu Zahiayixue Zazhi* 2010; 5: 1070-1071 [DOI: 10.3969/j.issn.1673-6966.2010.11.030] |
| 80   | Apovian CM, Aronne LJ, Bessesen DH, McDonnell ME, Murad MH, Pagotto U, Ryan DH, Still CD; Endocrine Society. Pharmacological management of obesity: an endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2015; 100: 342-362 [PMID: 25590212 DOI: 10.1210/jc.2014-3415] |
| 81   | Chinese Society of Endocrinology. Expert Consensus on the Treatment of Hyperuricemia and Gout in Chinese Patients. *Zhonghua Neifenmi Daixie Zazhi* 2013; 19: 913-920 [DOI: 10.3760/cma.j.issn.1000-6699.2013.11.001] |
| 82   | Chinese Society of Endocrinology. Expert Consensus on Comprehensive Management of Type 2 Diabetes Mellitus with Obesity in Chinese Patients. *Zhonghua Tangniaobing Zazhi* 2016; 8: 662-666 [DOI: 10.3760/cma.j.issn.1000-6699.2016.08.001] |
