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See Online for appendix

Promoting the term MAFLD: China in action

Changing the term non-alcoholic fatty liver disease to metabolic dysfunction-associated fatty liver disease (MAFLD) has gained increasing traction from numerous international and regional societies, including the Asian Pacific Association for the Study of the Liver, the Latin American Association for the Study of the Liver, the Chinese Society of Hepatology, the Malaysian Society of Gastroenterology and Hepatology, and the Arabic Association for the Study of Diabetes and Metabolism. Simultaneously, key stakeholders, such as policy makers, hepatologists, endocrinologists, nutritionists, the pharmaceutical industry, nurses, and patient advocates, have indicated strong support for this new term.[1–3]

China is not only a strong advocate for the MAFLD terminology and definition but is also a leading campaigner for change at the clinical interface.[4,5] Since 2020, 131 MAFLD clinics have been established across 30 provinces in China (appendix pp 1–4), all recognised by the Chinese Society of Hepatology. Clinical care is delivered by physicians and nurses according to standardised protocols and guidance from the Chinese Society of Hepatology, which includes minimum standards for the operation of clinics to improve the quality of care for patients with MAFLD (appendix pp 5–6).

The Chinese MAFLD Clinical Research Network has sought to establish a multidisciplinary care network, which involves hepatologists, endocrinologists, nutritionists, and pathologists, to evaluate metabolic risk in patients and develop holistic management approaches. Ultimately, the aim is to establish an all-in-one service for the integrated management of chronic metabolic disease, with a focus on MAFLD. We have developed a MAFLD screening panel to identify the presence of MAFLD and evaluate its severity within the constraints of our health-care system (appendix p 7). Our hope is to use these standardised tools and protocols to design optimal and personalised care plans to treat liver disease in the context of systemic metabolic dysfunction, which is the root cause of clinical adverse outcomes. Clinical experts on MAFLD pathophysiology from the Chinese MAFLD Clinical Research Network have conducted lectures, academic seminars, and patient education to ensure that new information is disseminated in a timely manner to non-specialist clinicians and patients alike. By use of the new MAFLD screening panel, the MAFLD clinics seek to better understand disease pathogenesis, evaluate metabolic risk factors, and prioritise care according to disease severity. We expect that the MAFLD clinics (with linkages to appropriate cardiometabolic care) will result in substantial improvements in the provision of high-quality chronic disease care, promote clinical and research efforts, and reduce the burden that MAFLD presents to China's tertiary specialist health-care system.[4]

We declare no competing interests.

*Xin-Lei Zhang, Jian-Gao Fan, Lai Wei, Jun-Ping Shi, *Ming-Hua Zheng, on behalf of the Chinese MAFLD Clinical Research Network*

zhengmh@wmu.edu.cn

MAFLD Research Center, Department of Hepatology, the First Affiliated Hospital of Wenzhou Medical University, Wenzhou 325000, China (X-LZ, M-HZ); Center for Fatty Liver, Department of Gastroenterology, Xin Hua Hospital Affiliated to Shanghai Jiao Tong University School of Medicine, Shanghai Key Laboratory Lab of Pediatric Gastroenterology and Nutrition, Shanghai, China (J-GF); Hepatopancreatobiliary Center, Beijing Tsinghua Changgung Hospital, School of Clinical Medicine, Tsinghua University, Beijing, China (LW); Department of Liver Diseases, Hangzhou Normal University Affiliated Hospital, Hangzhou, China (J-PS); Institute of Hepatology, Wenzhou Medical University, Wenzhou, China (M-HZ); Key Laboratory of Diagnosis and Treatment for the Development of Chronic Liver Disease in Zhejiang Province, Wenzhou, China (M-HZ)

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Hepatitis C in pregnancy and the TiP-HepC registry

Over a fifth of hepatitis C virus (HCV) infections occur in women of childbearing age.[1] At least 19 countries, including the USA, have policies or guidelines recommending universal HCV screening during pregnancy.[2] However, options for management and treatment of HCV infection during pregnancy are not well defined. Typical

clinical practice is to refer and link pregnant individuals for treatment after pregnancy and the breastfeeding period; however, in practice, very few are successfully treated.[3] Despite an excellent safety profile, direct-acting antivirals (DAAs) are not recommended for use in pregnancy. To date, only one prospective clinical trial has been published assessing HCV treatment in pregnancy.[4]

Several DAAs are categorised as class B in pregnancy, a category that also includes many prenatal vitamins, acetaminophen, and other medications routinely used in pregnancy. As of February, 2022, there were 68 unique pregnancy exposure registries listed by the US Food and Drug Administration for 143 medications or vaccines. No such registry has been established to assess the safety of DAAs for the treatment of HCV in pregnancy. The Infectious Diseases Society of America and the American Association for the Study of Liver Diseases suggest treatment be considered on an individual basis after discussion between the patient and provider and understanding of the risks and benefits of treatment.[5]

With support from the US Centers for Disease Control and Prevention, the Coalition for Global Hepatitis Elimination has developed the TiP-HepC (Treatment in Pregnancy for Hepatitis C) registry and is publicly launching this registry for data collection in June, 2022. The TiP-HepC registry collects clinical information and case reports primarily to assess pregnancy and birth outcomes after exposure to DAAs during pregnancy. Secondary outcomes include the effectiveness of treatment in pregnancy in achieving HCV cure for the mother and preventing HCV transmission from mother to infant. Retrospective data on the outcomes of mother–infant pairs exposed to DAAs during pregnancy in routine clinical practice will be solicited and collected from participating clinical providers, health-care facilities, HCV treatment programmes, and other clinical practices worldwide.

To achieve HCV cure for all, including mothers and children, providers and programmes need to understand the optimal approach to care for HCV infection in pregnancy, and establishing the safety of DAAs in pregnancy is paramount. We ask all clinicians and researchers active in the care of HCV in pregnancy to contribute data on DAA exposures in pregnancy to the TiP-HepC registry.

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*Neil Gupta, Lindsey Hiebert, Paige A Armstrong, Carolyn Wester, John W Ward
ngupta-consultant@taskforce.org

Coalition for Global Hepatitis Elimination, The Task Force for Global Health, Decatur, GA 230030, USA (NG, LH, JW); Division of Viral Hepatitis, US Centers for Disease Control and Prevention, Atlanta, GA, USA (PAA, CW)

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For the **FDA list of registries** see https://www.fda.gov/science-research/womens-health-research/list-pregnancy-exposure-registries

For the **TiP-HepC registry** see https://www.globalhep.org/evidence-base/treatment-pregnancy-hepatitis-c-tip-hepc-registry