With a health-care system challenged by deficiencies in financing and service delivery, the burden of alcohol-associated diseases is exacerbated in patients of lower socioeconomic status without access to care. Other clinically vulnerable groups in the Philippines, such as young people aged 11–16 years, are at risk for adverse health effects from alcohol consumption.[3] Targeted alcohol marketing and advertising exposure, compounded by poor implementation of restrictions, have been associated with increased alcohol consumption and intoxication among Filipino youth.[3]

More than half of Filipino people aged 20 years or older who drink alcohol engage in binge drinking (as defined by WHO), translating to 16 million individuals at risk of alcohol-related disability and death.[4] In 2012, the Philippine Sin Tax Law was passed with the aim of reducing alcohol and tobacco consumption and increasing health revenue for universal health coverage.[5] However, Filipino alcohol drinkers were not deterred by high prices, and the law's effect on alcohol consumption paled in comparison to its impact on tobacco use.[5] With the steady increase in alcohol consumption during the past decade and its disproportionate burden on the youth and those of lower socioeconomic status, a multi-faceted approach is needed to address the current burden of alcohol-related disability and death in the Philippines.

We agree with *The Lancet Gastroenterology & Hepatology* that there exists a crucial need to not only re-evaluate existing policies on alcohol use, but to also strengthen local multidisciplinary health services for the prevention and treatment of alcohol-related harm. Introducing advertising protections for clinically vulnerable groups, raising public awareness on the range of alcohol-associated diseases, and upbuilding capacity at community-level facilities are key strategies to curb worsening trends. Mobilising and coordinating the broad variety of stakeholders outside the health sector is crucial to addressing the socioeconomic determinants underlying alcohol-related disease and death.

We declare no competing interests.

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Global multi-stakeholder endorsement of the MAFLD definition

Comprising over 1000 signatories representative of multiple stakeholders, including hepatologists, internists, diabetologists, endocrinologists, paediatricians, primary-care providers, nephrologists, cardiologists, pathologists, patient advocates, nurses, nutritionists, and pharmaceutical experts from over 134 countries, we—the undersigned—endorse both the name metabolic (dysfunction)-associated fatty liver disease (MAFLD) as an overarching term and its definition for fatty liver diseases associated with metabolic dysregulation.[1–3] We advocate for this change because it more accurately reflects the underlying pathogenesis of the disease than does the previously used term, non-alcoholic fatty liver disease (NAFLD). Furthermore, we believe that this designation will enhance our ability to advance the science of fatty liver disease and to improve patient care.[4,5] This open letter represents the voices of individuals and multiple stakeholders across the global liver health community; it is not intended to devalue any other initiative, but to complement and inform them.

We publish this letter in response to substantial evidence showing the superior use of the MAFLD definition over that of NAFLD for patient awareness and management,[6–9] alignment with other diseases associated with metabolic dysregulation, advocacy for a more comprehensive approach to policies related to non-communicable diseases, and because the term is devoid of stigma.[10,11] Widespread adoption of the name and definition of MAFLD will allow for greater standardisation across the spectrum of disease and will help to set us on the path to a more cogent, coherent, and logical framework to understand, diagnose, and treat this commonly encountered condition.

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See **Online** for appendix

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See **Online** for appendix

Difficult-to-treat inflammatory bowel disease: results from a global IOIBD survey

A considerable proportion of patients with inflammatory bowel disease (IBD) are considered as having difficult-to-treat disease; however, no clear definition of difficult-to-treat IBD exists. As previously outlined,[1] with the support of the International Organization for the Study of IBD (IOIBD), we conducted a global qualitative survey of gastroenterologists to record opinions on aspects that affect patients with difficult-to-treat IBD. The full questionnaire and results are available in the appendix. In brief, questions covered the respondent's background and explored opinions on refractoriness to medical therapy and surgery, challenging disease characteristics, and perception of disease complexity. Invitations were distributed via email through the IOIBD and IBD-scope mailing lists, and registration prevented double participation. The relevance of each aspect was graded on a Likert scale; where applicable, proposed cutoffs were surveyed.

653 participants, with an average of 18 years' experience in gastroenterology and from 83 countries, completed the survey. Of these participants, 272 (42%) practised in Europe, 140 (21%) in South America, 119 (18%) in Asia, 47 (7%) in North America, 36 (6%) in Africa, 11 (2%) in Oceania, and 28 (4%) preferred not to answer. To strengthen the result, we restricted our analysis to the opinions of respondents treating more than 100 patients with IBD per year (448 of 653 participants); respondents with more than 10 years' experience and who were treating more than 500 patients per year were considered experts (102 of the 448 respondents).

Regarding medication history, 430 (96%) of 448 respondents agreed that failure of biologics or advanced small molecules is relevant to define difficult-to-treat IBD. 230 (52%) of 446 respondents supported a cutoff of failure of two or more advanced drugs and 141 (32%) supported a cutoff of failure of three or more such drugs (figure). 247 (55%) of 447 respondents considered patients to have difficult-to-treat disease if they had not responded or had lost response to advanced agents with at least two different mechanisms of action. Views were divided on the failure of immunomodulators, with 252 (56%) of 448 respondents indicating that patients for whom these drugs had not been successful should not be considered as having difficult-to-treat disease. The need for corticosteroids was considered to be relevant (339 [76%] of 448 participants agreed) but opioid dependency was not (only 175 [39%] of 447 respondents agreed). When restricting the analysis to the experts, opinions did not differ substantially.

309 (69%) of 448 respondents would include the need for surgery in the definition of difficult-to-treat Crohn's disease, and 287 (64%) of 447 participants proposed a cutoff of two or more resections; similarly, 370 (83%) of 448 respondents supported surgery as a criterion for difficult-to-treat ulcerative colitis. Other disease characteristics, comorbidities, and specific features were considered relevant; among these, treatment non-adherence, perianal disease in Crohn's disease, and concomitant presence of primary sclerosing cholangitis had the highest support.

In the context of increasingly personalised medicine, a definition of difficult-to-treat disease is essential to guide patient care and steer enrolment in clinical trials. Based on the results of this large survey, IOIBD plans to conduct a consensus agreement to propose common criteria for the definition of difficult-to-treat IBD.

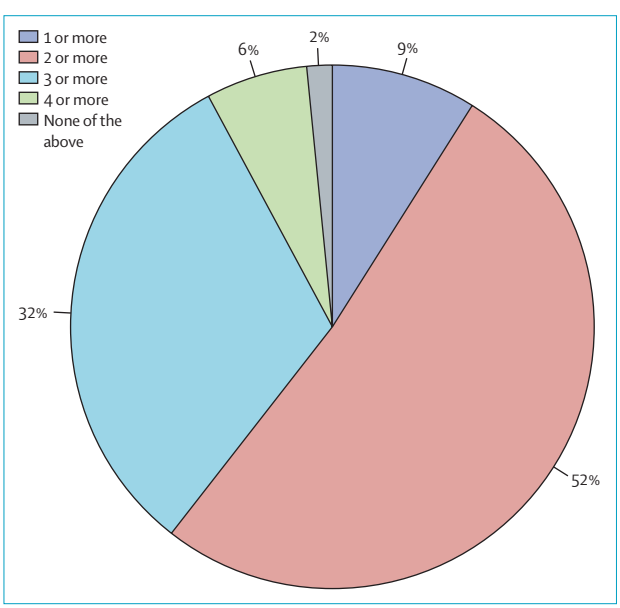

Figure: **Responses to the question: after the failure of how many biologics or advanced small molecules would you consider a patient as having difficult-to-treat disease?**
Owing to rounding, values in the pie chart exceed 100%.

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