



The internist, alphabet soup, and the hepatologist

We refer patients to internal medical subspecialists for a variety of reasons, sometimes for expediency, other times for help with diagnosis or therapy or to have a specific procedure performed.

Sometimes, in a specific sphere of medicine outside our immediate expertise, developments are so rapid or extensive that we realize we can no longer appropriately manage certain patients.

I was personally forced to confront this in 1994 after a 2-year hiatus from treating patients with human immunodeficiency virus. Although comfortable with making the diagnosis, I realized it was in my patients' best interests to refer them to an HIV specialist. I wonder if management of patients with viral hepatitis will follow the same pattern.

We physicians already have some angst about keeping up with changes in the diagnosis and treatment of viral hepatitis. We're not necessarily anxious about the alphabet soup of viruses to test for; rather, we're concerned about ordering the appropriate "liver" tests and correctly interpreting them. Granted, selecting the appropriate antiviral therapy—there are at least seven options—can be intimidating, but the hepatologist usually makes that decision. Rather, it is the increased understanding of the molecular pathobiology and the rapidly expanding spectrum of virus-induced clinical syndromes that requires our knowledge of serologic testing to be up to the minute. Not ordering and correctly interpreting the tests for hepatitis B prior to immunosuppression can result in potentially fatal immunosuppression-induced reactivation of the virus.

As Hanounch et al discuss in this issue (page 449), treatment decisions for hepatitis B infection sometimes must be made expediently, but these decisions require the appropriate interpretation of diagnostic "liver" tests which can—and often should—be ordered by us internists at the same time we refer the patient to a hepatologist.

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doi:10.3949/ccjm.76a.08001