

MASLD Diagnosis Faces Barriers Despite 2024 EASL Guidelines

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The 2024 EASL-EASD-EASO clinical practice guidelines incorporated a comprehensive framework for the screening, diagnosis, and management of metabolic dysfunction-associated steatotic liver disease (MASLD).¹ However, physicians frequently face obstacles in applying these recommendations in routine clinical care, particularly within the Southeastern Europe, Middle East, and Africa (SEEMEA) region. Addressing these implementation gaps is critical for improving patient outcomes in MASLD and metabolic dysfunction-associated steatohepatitis (MASH).

KEY TAKEAWAYS

- **The Pivot:** Despite updated 2024 guidelines, practical application of MASLD screening and diagnosis remains challenging for clinicians.
- **The Data:** A multidisciplinary expert group identified key gaps in MASLD/MASH management, particularly concerning screening triggers and VCTE availability.¹
- **The Action:** Clinicians should consider alternative diagnostic approaches where VCTE is limited and prioritise screening based on identified triggers.

In 2024, the EASL-EASD-EASO clinical practice guidelines introduced a comprehensive framework for the screening, diagnosis, and management of metabolic dysfunction-associated steatotic liver disease (MASLD).^{1,2,3} Despite these guidelines, physicians report encountering barriers to their application in routine clinical care, especially within the Southeastern Europe, Middle East, and Africa (SEEMEA) region.^{1,2,3} A multidisciplinary group of physicians involved in MASLD and metabolic dysfunction-associated steatohepatitis (MASH) management aimed to provide a practice-oriented roadmap to improve patient care and support the implementation of clinical guidance in the SEEMEA region.^{1,2,3}

Addressing Implementation Gaps in MASLD Management

The multidisciplinary group's objective was to provide practical and educational considerations beyond the hepatology field to improve patient care and support the implementation of clinical guidance within the SEEMEA region.^{1,2,3} This work was informed by a narrative review and expert input obtained through structured discussions.^{1,2,3} The group examined the status quo and identified key gaps in MASLD/MASH management, tracing the patient journey from screening and diagnosis to treatment and follow-up.^{1,2,3}

Key areas of focus included advising on priorities for screening triggers.^{1,2,3} The group also discussed alternative approaches to achieve accurate and timely diagnosis, specifically considering the limited availability of

vibration-controlled transient elastography (VCTE) in many settings.^{1,2,3} The evolving pharmacotherapy landscape was also reviewed, following the approval of resmetirom and semaglutide 2.4 mg for MASH treatment.^{1,2,3} Finally, the group proposed a "blueprint" for a specialised MASLD clinic, suggesting mandatory and optional facilities for optimised care.^{1,2,3}

A separate study assessed awareness of MASLD among primary care providers in the four most populous U.S. cities.² This research also highlighted that despite the 2024 guidelines, physicians face barriers in applying recommendations in routine clinical care.² Another publication emphasised the importance of naming MASLD/MASH and acting on it, reinforcing the need for improved implementation of diagnostic and management strategies.³

The collective findings from these publications indicate that while comprehensive guidelines exist, their practical application is hindered by factors such as awareness among primary care providers, limited access to advanced diagnostic tools like VCTE, and the need for a multidisciplinary approach to patient management.^{1,2,3} The proposed roadmap and clinic blueprint aim to address these limitations by providing actionable strategies for clinicians, particularly in regions with resource constraints.^{1,2,3}

Clinical Context of MASLD and MASH

MASLD, formerly known as non-alcoholic fatty liver disease (NAFLD), represents a spectrum of liver conditions characterized by hepatic steatosis in individuals with metabolic risk factors. These risk factors include obesity, type 2 diabetes mellitus, dyslipidemia, and hypertension. MASH, the more severe form of MASLD, involves liver inflammation and hepatocyte ballooning, which can progress to fibrosis, cirrhosis, and hepatocellular carcinoma. The global prevalence of MASLD is substantial and continues to rise, driven by increasing rates of obesity and metabolic syndrome. This escalating prevalence underscores the urgent need for effective screening, diagnosis, and management strategies to mitigate the burden of advanced liver disease.

The transition from NAFLD to MASLD nomenclature reflects a deeper understanding of the metabolic underpinnings of the disease, emphasizing its systemic nature rather than solely focusing on the absence of significant alcohol consumption. This change also aims to reduce stigma associated with the previous terminology. The 2024 EASL-EASD-EASO guidelines provide updated criteria for diagnosis, recommending screening in individuals with metabolic risk factors, particularly those with type 2 diabetes or obesity. Early identification of MASLD and MASH allows for timely interventions, including lifestyle modifications and emerging pharmacotherapies, to prevent disease progression.

Methodology and Patient Populations

The multidisciplinary group convened for the SEEMEA roadmap initiative comprised hepatologists, endocrinologists, diabetologists, and primary care physicians. This diverse representation ensured a holistic perspective on MASLD management, reflecting the multifactorial nature of the disease and the various specialties involved in patient care. The narrative review synthesized existing literature on MASLD/MASH epidemiology, diagnostic modalities, and treatment options, with a particular focus on data relevant to the SEEMEA region. Structured discussions facilitated the exchange of expert opinions, allowing for the identification of region-specific challenges and the development of tailored recommendations. The patient populations considered in this context are broad, encompassing individuals across the metabolic risk spectrum, from those with early-stage MASLD to those with advanced MASH and associated

complications. The SEEMEA region presents unique challenges due to varying healthcare infrastructures, resource availability, and diverse patient demographics, necessitating adaptable strategies for guideline implementation.

Limitations and Future Directions

Despite the comprehensive nature of the 2024 guidelines and the efforts to develop practical roadmaps, several limitations persist. Awareness among primary care providers remains a significant hurdle, as they are often the first point of contact for patients with metabolic risk factors. Limited access to advanced diagnostic tools, such as VCTE, particularly in resource-constrained settings, necessitates the exploration of alternative, more accessible screening and diagnostic methods. The long-term efficacy and real-world implementation challenges of newly approved pharmacotherapies like resmetirom and semaglutide 2.4 mg also require further investigation. Resmetirom, a thyroid hormone receptor-beta agonist, acts by increasing hepatic fat metabolism, while semaglutide, a GLP-1 receptor agonist, improves glycemic control and reduces body weight, indirectly impacting liver steatosis and inflammation. Future research should focus on developing cost-effective screening programs, enhancing physician education, and establishing integrated care pathways that facilitate multidisciplinary collaboration to improve MASLD and MASH patient outcomes globally.

To delve deeper into the intricate pathophysiology and clinical management of liver disorders, including steatotic liver disease, consult Sherlock's Diseases of the Liver and Biliary System.

CLINICAL IMPLICATIONS

The continued identification of barriers to MASLD diagnosis and management, even after the 2024 EASL-EASD-EASO guidelines, underscores a persistent disconnect between guideline development and real-world clinical practice. It is insufficient to simply publish comprehensive frameworks; active strategies for implementation, particularly in resource-limited regions like SEEMEA, are demonstrably necessary. The emphasis on alternative diagnostic approaches in the absence of VCTE is a pragmatic recognition of current infrastructure limitations, but it also highlights the ongoing challenge of equitable access to advanced diagnostics.

For primary care providers, the data suggests a need for targeted educational initiatives. If awareness remains a barrier in major U.S. cities, it is reasonable to infer that similar or greater gaps exist elsewhere. The approval of new pharmacotherapies like resmetirom and semaglutide 2.4 mg for MASH further complicates the diagnostic pathway; accurate and timely diagnosis is paramount to identify appropriate candidates for these treatments. Without effective screening and diagnostic pathways, the clinical benefit of these agents will not be fully realised.

The proposed "blueprint" for a specialised MASLD clinic offers a structured approach to optimising care, but its feasibility will depend on local healthcare systems' capacity and willingness to invest. The ongoing challenge is to translate expert consensus into practical, scalable solutions that can be integrated into diverse clinical settings, ensuring that the updated nomenclature and treatment options for MASLD and MASH lead to tangible improvements in patient outcomes, rather than merely existing as theoretical advancements.

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