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“We need to move away from putting all the responsibility on the individuals and recognise that behaviour is heavily shaped by factors beyond personal choice”

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Q1 Lifestyle modification remains the cornerstone of metabolic dysfunction-associated steatotic liver disease (MASLD) management, yet long-term patient adherence remains notoriously difficult. Why do conventional lifestyle interventions often fail in real-world practice?

Changing habits is difficult because these behaviours are established over decades, often from childhood. Weight loss is particularly challenging because the body actively resists it. When calorie intake falls, energy expenditure decreases as well, making sustained weight reduction difficult to achieve and even harder to maintain.

Many patients become discouraged when they encounter setbacks. It is therefore important to set realistic expectations from the outset and explain that periods of slower progress or temporary weight gain are a normal part of the process.

Another challenge is the environment people live in. Obesity and liver disease are often described as self-inflicted conditions, but that overlooks the influence of food environments, marketing, and commercial determinants of health. We need to move away from putting all the responsibility on the individuals and recognise that behaviour is heavily shaped by factors beyond personal choice.

Lifestyle treatment is a lifelong process rather than a short-term intervention. Patients need ongoing support, realistic goals, and regular follow-up if long-term success is to be achieved.

Q2 Given the limited time available during a standard consultation, what dietary advice should clinicians prioritise for patients newly diagnosed with MASLD?

Even brief consultations can be impactful. Many patients are unaware that liver disease is reversible in its earlier stages up to the stage of advanced liver scarring. Clinicians should use every encounter to emphasise that improving diet, increasing physical activity, reducing alcohol intake, and achieving modest weight loss can halt or even reverse disease progression.

I often recommend using the 5A model: ask permission to discuss lifestyle, assess current habits with open questions and without judgment, advise on changes, agree on realistic goals, and assist with follow-up and overcoming barriers.

Importantly, I do not focus solely on weight loss. Small, achievable dietary changes can have a meaningful impact. Replacing sugar-sweetened beverages with water, for example, can significantly benefit liver health.

Positive reinforcement is equally important. Patients should be recognised for progress, however small, because building confidence and self-efficacy is essential for long-term behaviour change.

Q3 Intermittent fasting has become increasingly popular among patients. What does the evidence currently show?

Intermittent fasting has attracted considerable interest because of

its potential metabolic benefits. Randomised clinical trials suggest that when calorie reduction and weight loss are comparable, intermittent fasting performs similarly to conventional healthy dietary approaches in reducing liver fat and markers of liver scarring (fibrosis).

In other words, intermittent fasting is not necessarily superior, but it is an effective option for many patients. One of its advantages may be behavioural rather than physiological. Restricting eating windows can help reduce evening snacking and emotional eating, which are major contributors to excess calorie intake, especially coming from unhealthy foods we tend to eat at night in front of screens.

For patients who find it convenient and sustainable, intermittent fasting can be a useful tool. However, it is not suitable for everyone. Patients with cirrhosis or advanced liver disease should avoid prolonged fasting because it can accelerate muscle loss and worsen nutritional status.

Q4 You have long advocated for structural public health approaches alongside individual lifestyle interventions. Which policy measures could have the greatest impact on reducing liver disease burden?

Although direct evidence linking individual policies to reductions in MASLD prevalence remains limited, modelling studies suggest that population-level interventions could substantially reduce liver disease burden, liver cancer, and liver-related mortality.

Among the most promising measures are taxation of sugar-sweetened beverages and alcohol, warning labels on

harmful products, and restrictions on unhealthy food marketing. However, a combination of several approaches would have a greater impact. Healthy foods must also become more affordable and accessible. Taxation should be accompanied by subsidies for healthier options, alongside public education and awareness campaigns.

Education is particularly important because prevention starts early. Children who learn about nutrition and liver health often bring those messages home, influencing entire families. Integrating liver health into school curricula could therefore become an important preventive strategy.

Q5 With the rapid emergence of glucagon-like peptide-1 (GLP-1) receptor agonists and other pharmacological therapies for metabolic dysfunction-associated steatohepatitis, what role will lifestyle medicine continue to play?

Lifestyle medicine will remain fundamental. These medications are highly effective, but they do not replace healthy eating and physical activity.

The benefits of lifestyle interventions extend far beyond weight reduction. They improve cardiovascular health, reduce cancer risk, enhance mental wellbeing, and improve quality of life. Those benefits cannot be replicated by medication alone.

In fact, nutritional support becomes even more important when patients receive weight-loss medications. Rapid weight loss can increase the risk of muscle loss, nutritional deficiencies, and gastrointestinal side effects. Dietitians therefore have a

crucial role in supporting patients receiving pharmacological treatment.

The future is not lifestyle medicine versus medication. It is the combination of both.

Q6 Looking ahead 5–10 years, how do you expect MASLD management to evolve?

I hope we will see much greater recognition of prevention and nutrition within healthcare systems. Access to dietitians should become routine, particularly for patients with obesity, Type 2 diabetes, and liver disease.

I also expect digital tools, mobile applications, and AI to play a larger role in supporting behavioural change and providing ongoing patient support between in-person professional consultations.

Pharmacological therapies will undoubtedly become more common, but long-term success will still depend on helping patients adopt sustainable lifestyle changes. The greatest opportunity remains prevention: improving nutrition, increasing physical activity, reducing alcohol consumption, and creating environments that make healthy choices easier.

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