THE GLOBAL PULSE OF HEALTHCARE · PRIMARY CARE & FAMILY MEDICINE INSIGHT REPORT

MASLD in Primary Care: When Metabolic Risk Should Trigger Fibrosis Assessment

Responses from family physicians and general practitioners on how MASLD enters primary-care assessment: which metabolic-risk profiles trigger action, what happens when liver enzymes are normal, how non-invasive fibrosis tools are used, where referral confidence is strongest, and which system gaps slow earlier risk stratification.

Metabolic risk → Fibrosis assessment → Triage → Referral

518	6	71.4%	8974049
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate	Survey ID

WHY THIS REPORT

MASLD can enter primary care through a metabolic-risk conversation long before a patient has a liver-specific complaint.

Family physicians and general practitioners routinely manage obesity, type 2 diabetes, prediabetes, dyslipidemia, hypertension, abnormal liver tests, and incidental imaging findings. Those are also common entry points into MASLD risk. The clinical challenge is deciding when a familiar cardiometabolic profile should trigger a liver-fibrosis assessment rather than another period of observation.

That decision is not solved by symptoms or aminotransferases alone. MASLD can be clinically quiet, and liver enzymes may be normal even when fibrosis risk deserves attention. Primary care therefore has to connect three different layers: who is at risk, which non-invasive test should come next, and which results can be followed locally versus referred to gastroenterology or hepatology.

The MDForLives survey examines that handoff point in real-world primary care: the patient profiles that prompt assessment, clinician response to normal liver enzymes, current use of FIB-4 and elastography, confidence around referral, ongoing metabolic management, barriers to implementation, and the changes FPs and GPs believe would make earlier identification more practical.

> **Survey lens.** MDForLives survey SGID 8974049 includes 518 survey records with a 71.4% completion rate across 6 countries: USA · UK · Canada · Italy · France · Germany. Response totals vary by item, and multi-select questions are interpreted as option-level selections rather than as mutually exclusive categories. Internal operational, required-text, after-survey, and honeypot fields are excluded from analysis.

CLINICAL CONTEXT

Current MASLD pathways move the trigger upstream: from abnormal liver tests toward cardiometabolic risk and structured fibrosis assessment.

The AGA's updated 2026 clinical care pathway recommends a stepwise strategy for high-risk patients that begins with risk identification and non-invasive fibrosis stratification. The pathway highlights three major groups: people with type 2 diabetes, people with overweight or obesity plus additional metabolic risk, and people with incidental hepatic steatosis or elevated aminotransferases. It also emphasizes that primary care is one of the settings in which most people with MASLD are evaluated and managed.

The 2024 EASL-EASD-EASO clinical practice guideline similarly defines MASLD around steatotic liver disease plus cardiometabolic risk and supports case-finding for fibrosis in people with metabolic risk, abnormal liver enzymes, or radiological steatosis, particularly type 2 diabetes and obesity with additional metabolic risk.

The AASLD guidance adds an important primary-care caution: aminotransferase levels can be normal in advanced disease and should not be used in isolation to exclude clinically significant fibrosis. It describes FIB-4 as a first-line risk-assessment tool, with secondary non-invasive testing or specialist evaluation when risk is higher or results are uncertain.

Context for interpretation: These external pathways provide clinical context rather than a scorecard for the MDForLives respondents. The survey captures what clinicians report doing in practice across six countries, where test availability, referral pathways, reimbursement, and local guidance can differ.

EXECUTIVE SUMMARY

Six signals showing where primary-care MASLD assessment is working, and where the pathway still loses momentum.

INSIGHT 01

Metabolic risk already triggers attention

90.6% select obesity, dyslipidemia, or hypertension with metabolic risk as a profile that would prompt MASLD assessment.

INSIGHT 02

Assessment is more selective than routine

41.0% say MASLD assessment is incorporated selectively according to the patient's metabolic risk profile.

INSIGHT 03

Normal liver enzymes do not settle the decision

34.7% say further assessment is likely depending on the clinical picture, while 29.9% say it is very likely with multiple risk factors.

INSIGHT 04

Fibrosis assessment uses multiple routes

56.8% report elastography use and 53.1% use FIB-4 or other structured fibrosis scores.

INSIGHT 05

Higher fibrosis risk usually triggers referral

57.9% say gastroenterology or hepatology referral is their usual next step after a higher-risk non-invasive assessment.

INSIGHT 06

Access to testing is both barrier and solution

56.7% identify limited testing access as a barrier; 58.4% select better testing access and decision support as a leading improvement.

01

RISK RECOGNITION

Primary care already recognizes the metabolic profiles that should put MASLD on the assessment radar

90.6% select obesity, dyslipidemia, or hypertension with metabolic risk as a reason to consider MASLD assessment.

CONTEXT

MASLD rarely arrives in primary care as an isolated liver problem. It is more likely to sit inside an established metabolic story: excess weight, dyslipidemia, hypertension, prediabetes, type 2 diabetes, or a combination of those conditions. The practical question is whether those familiar risk factors are treated as a reason to look for fibrosis risk.

WHAT THE DATA SHOWS

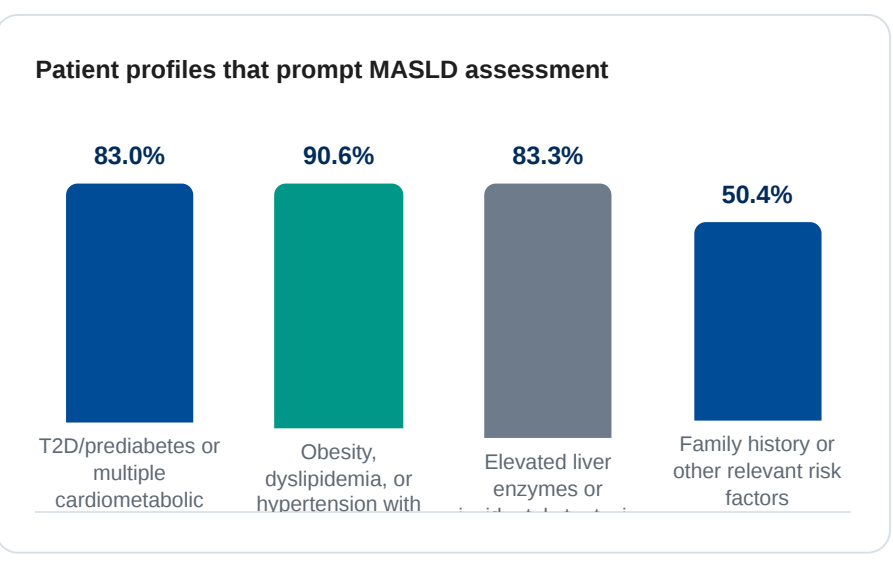
Obesity, dyslipidemia, or hypertension with metabolic risk is the most selected assessment trigger at 90.6%. Persistently elevated liver enzymes or incidentally detected steatosis follows at 83.3%, while type 2 diabetes, prediabetes, or multiple cardiometabolic risk factors is selected by 83.0%. Family history or other relevant risk factors is selected by 50.4%.

THE INSIGHT

The leading signals are not liver-specific. They are the same cardiometabolic factors that FPs and GPs already review in routine care. That creates an opportunity to identify MASLD risk without waiting for a new symptom, but only if metabolic risk is connected to a defined liver-risk pathway.

WHY IT MATTERS

When risk identification is embedded in diabetes, obesity, hypertension, or lipid care, MASLD assessment can begin at a point when the patient is already visible to the health system. The next challenge is making the transition from recognition to structured fibrosis assessment consistent.


Patient profiles that prompt MASLD assessment

02

ROUTINE VERSUS SELECTIVE ASSESSMENT

Risk recognition is broad, but routine MASLD assessment has not yet become the default primary-care workflow

41.0% incorporate MASLD assessment selectively according to the patient's metabolic risk profile.

CONTEXT

Recognizing a high-risk patient is different from having a repeatable screening process. A routine pathway defines who should be assessed, what first-line test is used, how often risk is revisited, and what result triggers the next step. A selective pathway leaves more of that sequence to individual clinical judgement.

WHAT THE DATA SHOWS

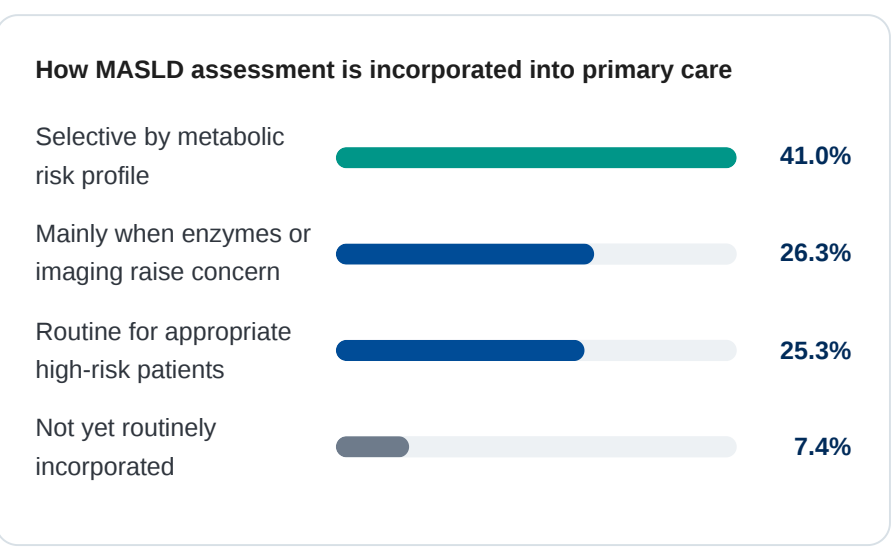
41.0% say MASLD assessment is incorporated selectively based on the patient's metabolic risk profile. 25.3% report routine assessment for appropriate high-risk patients. Another 26.3% say assessment happens mainly when abnormal liver enzymes or imaging raise concern, while 7.4% say it is not yet routinely incorporated.

THE INSIGHT

The largest group is already risk-based, but not fully protocolized. That means primary care is not waiting only for abnormal liver tests, yet the assessment trigger may still depend on how each clinician weighs obesity, diabetes, other metabolic risk, liver chemistry, and imaging.

WHY IT MATTERS

The 2026 AGA pathway and the EASL-EASD-EASO guideline both make targeted case-finding more explicit. Translating that into practice requires the trigger to live inside workflows clinicians already use, rather than depending on a separate liver-disease process that may never start.


How MASLD assessment is incorporated into primary care

03

NORMAL LIVER ENZYMES

A normal liver-enzyme result does not produce one consistent primary-care response when metabolic risk is high

34.7% say further assessment is likely depending on the overall clinical picture; 29.9% say it is very likely with multiple risk factors.

CONTEXT

Normal aminotransferases can feel reassuring because liver chemistry is familiar, available, and easy to revisit. MASLD complicates that logic because fibrosis risk and liver-enzyme elevation do not move in perfect parallel. A patient can have substantial metabolic risk without an abnormal biochemical signal.

WHAT THE DATA SHOWS

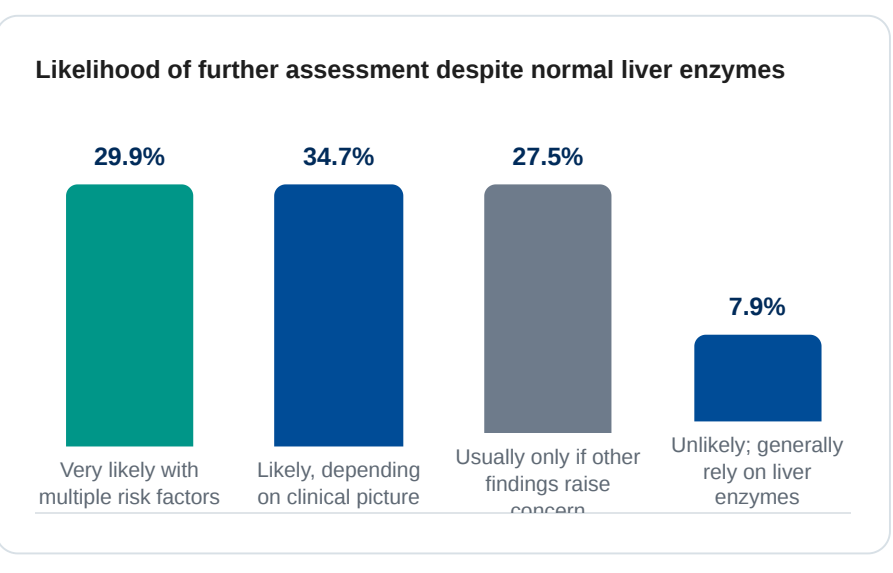
The responses are distributed across four positions. 34.7% say they are likely to pursue further assessment depending on the overall clinical picture. 29.9% say they are very likely to do so, especially with multiple risk factors. 27.5% usually proceed only if other findings raise concern, and 7.9% are unlikely to investigate further and generally rely on liver enzymes first.

THE INSIGHT

Normal enzymes create an uncertainty zone rather than a hard stop. The two largest groups continue to use clinical risk as a reason to consider further assessment, but a substantial share still waits for another signal. That variation can affect how early silent fibrosis is identified.

WHY IT MATTERS

The AASLD practice guidance states that aminotransferases are frequently normal in advanced disease and should not be used alone to exclude clinically significant fibrosis. Primary care therefore needs a route from metabolic risk to non-invasive fibrosis assessment even when routine liver chemistry is not abnormal.


Likelihood of further assessment despite normal liver enzymes

04

NON-INVASIVE FIBROSIS TOOLS

FIB-4 and elastography are both present in primary-care practice, but the sequence between them may be the missing standard

56.8% report transient elastography or FibroScan use; 53.1% report FIB-4 or another structured fibrosis score.

CONTEXT

Fibrosis risk changes the clinical significance of MASLD. Primary care does not need to diagnose every stage with one test, but it does need a practical way to separate lower-risk patients from those who need additional assessment or specialty input.

WHAT THE DATA SHOWS

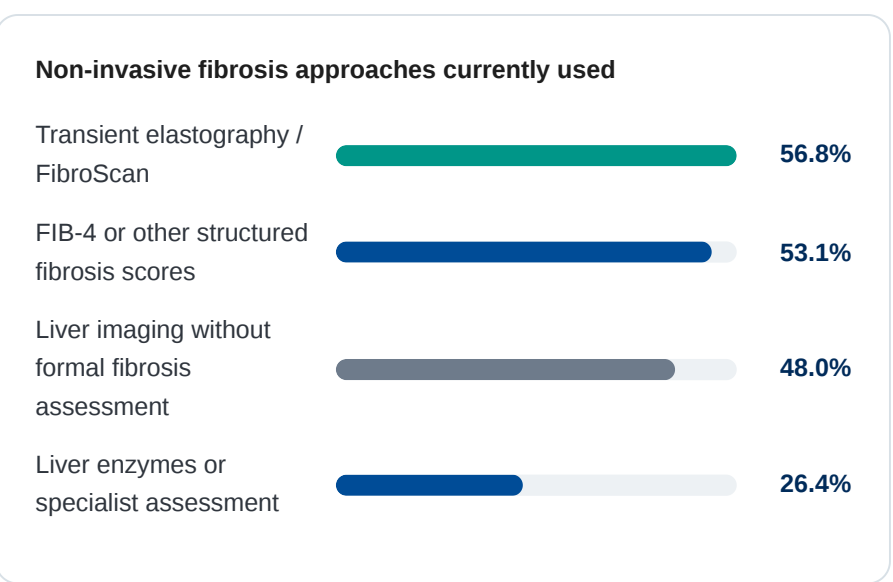
56.8% report using transient elastography, FibroScan, or another elastography approach. 53.1% use FIB-4 or other structured fibrosis scores. 48.0% use liver imaging without formal fibrosis assessment, and 26.4% say they primarily rely on liver enzymes or specialist assessment.

THE INSIGHT

The data does not suggest an absence of fibrosis tools. It suggests a mixed testing environment. Some clinicians have access to structured scores, some to elastography, some to general imaging, and some still lean on specialist assessment. The problem can therefore be one of sequencing and access as much as awareness.

WHY IT MATTERS

Current pathways commonly use a two-step model: a simple first-line score such as FIB-4 followed, when indicated, by liver-stiffness measurement or another second-tier test. The AGA pathway explicitly frames this as a way to identify who can remain in primary care and who needs specialty evaluation. A predictable sequence can reduce both unnecessary referral and missed higher-risk disease.


Non-invasive fibrosis approaches currently used

05

REFERRAL CONFIDENCE

The referral decision is familiar, but only a minority describe very high confidence in where the primary-care boundary sits

51.2% are quite or moderately confident deciding who can remain in primary care and who requires specialist referral.

CONTEXT

A fibrosis pathway only works when the handoff is clear. Lower-risk patients may be monitored in primary care, while higher-risk or uncertain cases may need gastroenterology or hepatology. The difficult group is often the patient in between: enough risk to require attention, but not an obvious specialty referral from the first encounter.

WHAT THE DATA SHOWS

51.2% describe themselves as quite or moderately confident making the primary-care-versus-specialist decision. 18.1% are very confident. 25.1% are only slightly confident, and 5.6% are not confident.

THE INSIGHT

Moderate confidence can be clinically workable, but it also signals that referral criteria are not always self-evident. Confidence may depend on local access to elastography, the availability of clear thresholds, whether test results are discordant, and whether specialist advice can be obtained without a full referral.

WHY IT MATTERS

A pathway that clarifies both sides of the decision can protect scarce specialist capacity. It should make lower-risk follow-up in primary care explicit while also defining the findings that warrant second-tier testing, consultation, or referral.

Confidence deciding primary care versus specialist referral

51.2% Quite / moderately confident	**18.1%** Very confident
25.1% Slightly confident	**5.6%** Not confident

06

WHEN RISK RISES

Once non-invasive assessment suggests advanced fibrosis risk, specialist referral becomes the dominant next step

57.9% refer to gastroenterology or hepatology after a higher-risk non-invasive assessment.

CONTEXT

The value of a non-invasive fibrosis test is not simply the number it produces. It is the action it triggers. A higher-risk result can lead directly to referral, prompt another non-invasive test, trigger closer primary-care monitoring, or generate a specialist discussion before the pathway is changed.

WHAT THE DATA SHOWS

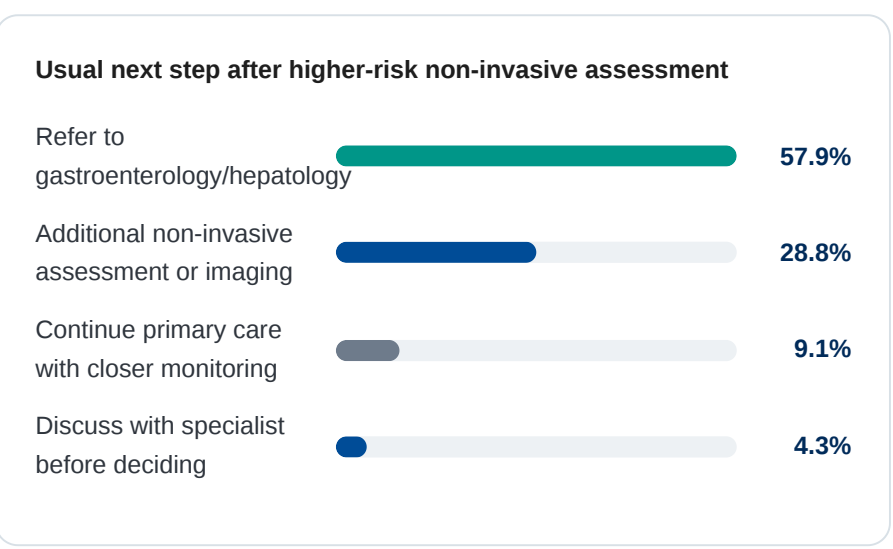
57.9% say their usual next step is referral to gastroenterology or hepatology. 28.8% perform additional non-invasive assessment or imaging before referral. 9.1% continue primary-care management with closer monitoring, while 4.3% discuss the case with a specialist before deciding.

THE INSIGHT

Referral is the dominant response once risk is elevated, but almost three in ten respondents prefer another diagnostic step first. That can be appropriate in structured pathways, but it also makes access to the right second-tier test important. If that test is difficult to obtain, the patient can stall between an abnormal risk signal and a definitive handoff.

WHY IT MATTERS

The survey's referral result and its testing-access result reinforce each other. A pathway that relies on staged risk stratification must make the next test available quickly enough that it does not become a new bottleneck before specialty care.


Usual next step after higher-risk non-invasive assessment

07

MANAGEMENT IN PRIMARY CARE

MASLD management already overlaps heavily with the cardiometabolic work FPs and GPs do every day

85.9% address glycaemic, lipid, and blood pressure management in patients with MASLD under their care.

CONTEXT

Identifying fibrosis risk does not replace management of the metabolic conditions that travel with MASLD. Weight, diet, physical activity, glycaemia, blood pressure, and lipids remain part of the primary-care workload whether or not a hepatology referral is needed.

WHAT THE DATA SHOWS

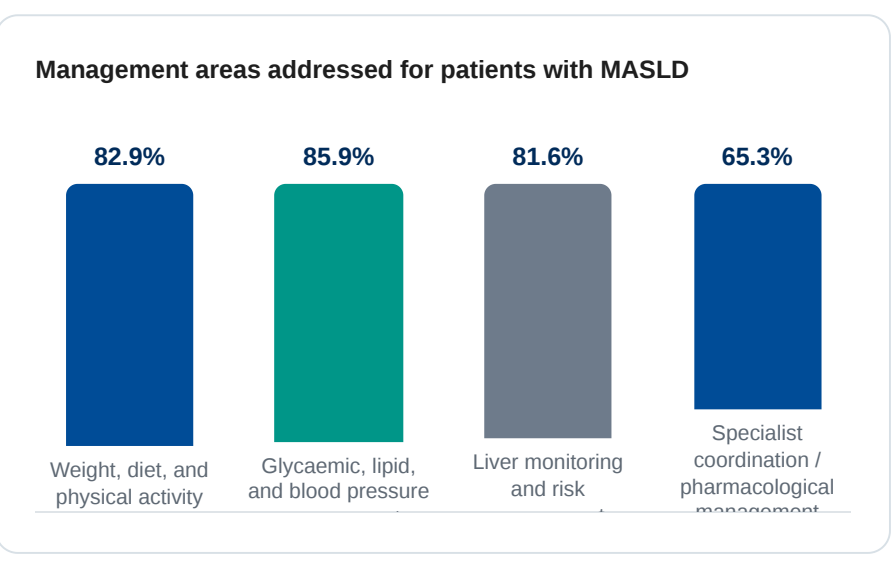
85.9% address glycaemic, lipid, and blood pressure management. 82.9% address weight, diet, and physical activity. 81.6% report liver monitoring and risk assessment, and 65.3% report coordination with gastroenterology/hepatology or pharmacological management.

THE INSIGHT

MASLD care is not being described as a liver-only pathway. The three most selected management areas cluster tightly around metabolic risk-factor management and liver-risk monitoring. This gives primary care an ongoing role even when specialist input is added.

WHY IT MATTERS

Integration is therefore more practical than creating a parallel disease program. A workflow that surfaces liver risk inside diabetes, obesity, lipid, or hypertension management can keep fibrosis assessment connected to the broader risk profile and reduce duplicated care.


Management areas addressed for patients with MASLD

08

IMPLEMENTATION BARRIERS

The biggest friction sits in access to testing, time, and the connective tissue between assessment and follow-up

56.7% identify limited access to fibrosis testing and diagnostic tools as a barrier.

CONTEXT

A primary-care fibrosis pathway can be clinically sound and still fail operationally. The clinician needs enough time and familiarity to identify risk, access to the recommended test, a way to act on the result, and a referral or follow-up route that does not leave responsibility ambiguous.

WHAT THE DATA SHOWS

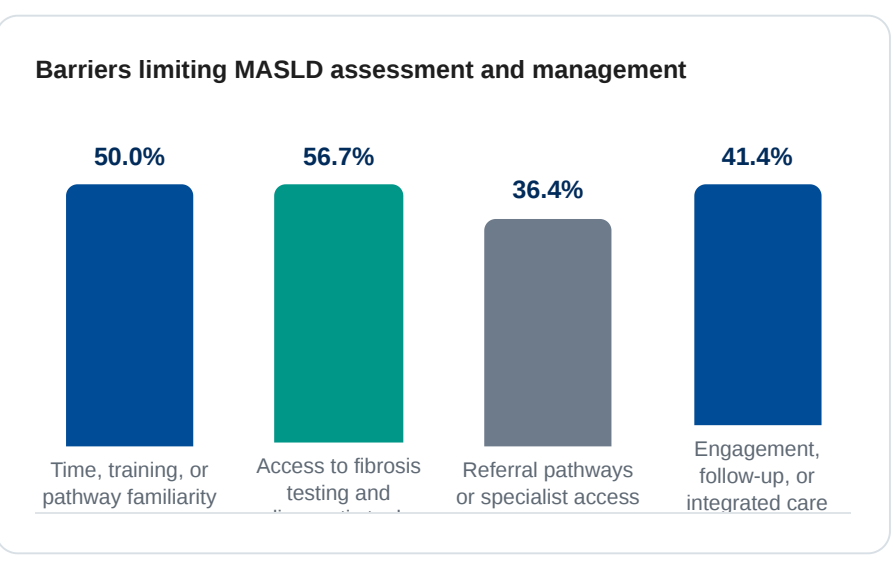
Limited access to fibrosis testing and diagnostic tools is selected by 56.7%. Limited time, training, or familiarity with MASLD pathways follows at 50.0%. Patient engagement, follow-up, or lack of integrated care pathways is selected by 41.4%, while unclear referral pathways or limited specialist access is selected by 36.4%.

THE INSIGHT

The barriers form a chain. Even if the right patient is identified, testing access can slow the next step. Even if testing is available, limited time or training can make interpretation harder. Even if risk is identified, unclear referral or follow-up ownership can break continuity.

WHY IT MATTERS

MASLD implementation should therefore be judged by pathway reliability, not by the presence of one test or guideline. The effective pathway is the one that makes each next action available at the point it is needed.


Barriers limiting MASLD assessment and management

09

CONNECTED PATHWAY

The clinicians' preferred fixes point toward one connected pathway from metabolic risk to fibrosis action

58.4% prioritize greater access to non-invasive fibrosis testing and decision support;
50.9% prioritize clearer screening, risk-assessment, and referral pathways.

CONTEXT

The survey asks what would make earlier MASLD identification and management more effective in primary care. The leading answers are not isolated interventions. They connect risk recognition, testing, interpretation, and referral.

WHAT THE DATA SHOWS

58.4% select greater access to non-invasive fibrosis testing and clinical decision support. 50.9% select clearer screening, risk-assessment, and referral pathways. 35.4% select better integration of MASLD with diabetes, obesity, and cardiometabolic care, while 21.7% select greater FP/GP education and faster specialist access.

THE INSIGHT

The strongest improvement signals match the strongest barriers. Testing access is both the leading constraint and the leading requested change. Clearer pathways rank next. Together, they suggest that clinicians do not simply need to know more about MASLD; they need the pathway to make the next action easier to execute.

WHY IT MATTERS

A connected pathway can start with a metabolic-risk trigger, apply a simple first-line fibrosis assessment, move higher-risk or uncertain patients to an accessible second-tier test, clarify referral thresholds, and keep metabolic management active regardless of who owns the liver-specific evaluation. That is the operational bridge between risk awareness and earlier fibrosis detection.

Four points where the pathway needs to connect

90.6% Metabolic risk can trigger assessment	**53.1%** Use FIB-4 or structured fibrosis scores
57.9% Refer after a higher-risk non-invasive result	**58.4%** Want better testing access + decision support

OPEN RESPONSE LENS

When FPs and GPs describe what would improve MASLD care, they ask for clearer pathways and easier access to the tools that make those pathways usable.

The open-ended item asked respondents to name one change in guidance, diagnostic tools, treatment options, referral pathways, or healthcare systems that would most improve their ability to identify and manage MASLD in primary care. The visible responses are brief and heterogeneous, and they should not be converted into prevalence percentages without formal coding.

Qualitatively, however, the comments reinforce the quantitative results. Respondents repeatedly mention access to imaging, FibroScan, non-invasive testing, approval or coverage for tests, and the need for clearer guidance on screening and referral. One response describes an integrated diagnostic-therapeutic pathway with automated FIB-4 calculation inside general-practice software, followed by timely specialist referral when advanced fibrosis risk is identified. Other comments call for training, more time for lifestyle counseling, earlier detection, a reliable blood test, and clearer diagnostic or treatment algorithms.

Access to fibrosis testing

FibroScan, imaging, non-invasive tests, and easier access to testing are recurring requests, mirroring the leading quantitative barrier.

Clear screening and referral guidance

Respondents ask for clearer rules on who to screen, how often to assess, which methods to use, and when gastroenterology or hepatology referral is appropriate.

Decision support inside primary care

One response explicitly proposes automated FIB-4 calculation within general-practice software, connecting risk scoring to a defined referral pathway.

Training, time, and experience

Several comments point to education, clinician experience, and more consultation time, including time for counseling around lifestyle modification.

Coverage and approvals

Some respondents describe test coverage or approval as the missing practical step, showing how financing can shape whether a pathway is usable.

New diagnostic options

Minority comments mention a reliable blood test and treatment options, adding a forward-looking diagnostic and therapeutic dimension to the implementation discussion.

> **What the open responses add:** The quantitative results identify testing access and pathway clarity as major needs. The comments show what that means in practice: shorter waits, approved tests, usable algorithms, embedded FIB-4 calculation, clinician training, and a referral process that activates when risk rises.

PEOPLE ALSO ASK · TOPIC FAQ

Frequently asked questions about MASLD in primary care.

What is MASLD?

MASLD, or metabolic dysfunction-associated steatotic liver disease, describes steatotic liver disease in a person with at least one cardiometabolic risk factor. It replaces the former NAFLD terminology within the updated steatotic liver disease classification.

Who should be assessed for MASLD in primary care?

Current guidance supports targeted assessment in higher-risk groups, particularly people with type 2 diabetes, overweight or obesity plus additional metabolic risk, incidental hepatic steatosis, or unexplained liver-enzyme elevation. Local pathways and patient context should guide implementation.

Can MASLD be present with normal liver enzymes?

Yes. Normal aminotransferase levels do not reliably exclude MASLD or clinically important fibrosis. Metabolic risk, imaging, and structured non-invasive fibrosis assessment may still be relevant when liver enzymes are not elevated.

What is FIB-4 and how is it used in primary care?

FIB-4 is a non-invasive fibrosis risk score calculated from age, AST, ALT, and platelet count. It is commonly used as a first-line risk-stratification tool to identify patients who may need second-tier testing or specialist evaluation.

When is FibroScan or elastography used in MASLD?

Transient elastography, including FibroScan, measures liver stiffness and is commonly used as a second-tier non-invasive assessment after an initial risk score or when clinical risk warrants further fibrosis evaluation.

When should primary care refer suspected MASLD to gastroenterology or hepatology?

Referral is generally considered when non-invasive testing suggests higher fibrosis risk, results are indeterminate or discordant, another liver disease is suspected, or local pathways specify specialist evaluation. Thresholds and referral criteria vary by health system and guidance.

PRIMARY CARE MASLD LENS

What this means at four points in the primary-care pathway.

The survey suggests that earlier MASLD identification depends less on one perfect test than on a sequence that clinicians can trigger consistently, interpret confidently, and connect to follow-up or referral.

When metabolic risk is recognized

Trigger lens. Make obesity, diabetes, prediabetes, dyslipidemia, hypertension, incidental steatosis, and other relevant risk visible as prompts for structured MASLD assessment.

When liver enzymes are normal

Risk-stratification lens. Do not let a normal aminotransferase result become the only reason to stop assessment when cardiometabolic risk remains clinically important.

When first-line risk is not low

Second-tier lens. Make the next non-invasive fibrosis test or specialist pathway explicit so an intermediate or higher-risk result does not stall between settings.

While referral or follow-up continues

Integrated-care lens. Continue weight, glycaemic, lipid, blood-pressure, lifestyle, and liver-risk management rather than treating specialist referral as the end of primary-care ownership.

CLOSING PERSPECTIVE

The next step for MASLD in primary care is not more risk awareness. It is a pathway that makes fibrosis action easier to repeat.

The MDForLives findings describe a primary-care audience that already recognizes the major metabolic profiles associated with MASLD. Obesity, dyslipidemia, hypertension, diabetes, prediabetes, elevated liver enzymes, and incidental steatosis are all familiar triggers. The gap appears after recognition, when the clinician has to decide how aggressively to assess, which non-invasive test is available, how much confidence to place in a normal liver-enzyme result, and when specialist referral is justified.

The normal-enzyme result captures that uncertainty particularly well. Respondents do not treat it uniformly. Some continue assessment when metabolic risk is strong; others wait for another finding. Current guidance increasingly supports risk-based fibrosis assessment because aminotransferases alone do not reliably exclude clinically important fibrosis. That makes the workflow around FIB-4, elastography, and second-tier testing more consequential than any single laboratory result.

The survey also shows that primary care is not starting from zero. More than half report FIB-4 or structured fibrosis-score use, and a similar share report elastography. Once a higher-risk non-invasive result appears, referral to gastroenterology or hepatology becomes the dominant next step. At the same time, confidence around the broader referral boundary is mostly moderate rather than very high, suggesting that the middle of the pathway remains less standardized than the endpoints.

Implementation is where the findings converge. Limited access to fibrosis testing and diagnostic tools is the most selected barrier, and greater access to non-invasive testing and clinical decision support is the most selected improvement. Clearer screening and referral pathways rank close behind. The open comments repeat the same needs in practical language: access to FibroScan and imaging, testing approvals, clearer algorithms, embedded FIB-4 calculation, training, and shorter waits.

The primary-care opportunity is therefore to connect what is already happening. Metabolic risk is being recognized. Cardiometabolic conditions are already being managed. Non-invasive tools are already used by many clinicians. The missing piece is a reliable bridge between those activities: a trigger for assessment, a first-line risk step, an accessible second-tier option, a defined referral threshold, and continued metabolic management while the liver pathway progresses.

1 · Put MASLD inside cardiometabolic workflows

Use diabetes, obesity, dyslipidemia, hypertension, and incidental steatosis as practical opportunities to trigger liver-risk assessment where local guidance supports it.

2 · Make the first fibrosis step easy

Build structured risk assessment into routine data and workflow so clinicians do not need to create a separate process for every high-risk patient.

3 · Do not let normal enzymes end the reasoning

Interpret liver chemistry alongside metabolic risk, imaging, and non-invasive fibrosis assessment rather than as a stand-alone rule-out.

4 · Connect first-line and second-tier testing

Ensure that a higher or uncertain initial risk result can lead to an available next test without unnecessary delay or duplicated work.

5 · Clarify the referral boundary

Define which patients can remain under primary-care monitoring and which findings should trigger specialist consultation or referral.

6 · Keep metabolic management active

Continue weight, glycaemic, lipid, blood-pressure, lifestyle, and follow-up work regardless of whether liver-specific care remains in primary care or is shared with a specialist.

Help future primary-care liver insights reflect what happens before specialist referral.

Join MDForLives to share clinical perspectives on metabolic risk, fibrosis assessment, referral pathways, testing access, and integrated MASLD care.

Join the Panel

REFERENCES AND DATA SOURCE

Sources used for this report

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2. **American Gastroenterological Association.** Updated clinical care pathway for metabolic dysfunction-associated steatotic liver disease, 2026. AGA / GI & Hepatology News.
3. **European Association for the Study of the Liver, European Association for the Study of Diabetes, and European Association for the Study of Obesity.** Clinical Practice Guidelines on the management of metabolic dysfunction-associated steatotic liver disease, 2024. EASL.
4. **Rinella ME, Neuschwander-Tetri BA, Siddiqui MS, et al.** AASLD Practice Guidance on the clinical assessment and management of nonalcoholic fatty liver disease, 2023, with subsequent MASLD nomenclature and therapy updates listed by AASLD. AASLD guidance hub.

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