MDForLives

THE GLOBAL PULSE OF HEALTHCARE · GASTROENTEROLOGY & HEPATOLOGY INSIGHT REPORT

MASLD Screening: Why Earlier Fibrosis Detection Still Breaks Down

Responses from gastroenterology and hepatology clinicians on MASLD case-finding: who is screened most often, why silent disease delays detection, how FIB-4 and elastography are used, where primary-care referrals land on the fibrosis spectrum, and what could make earlier F2–F3 identification more consistent.

Context → Signal → Judgement → Action

45	**5**	**68.9%**	**8935001**
Survey records	Countries represented USA · UK · Italy · France · Germany	Completion rate	Survey ID

WHY THIS REPORT

MASLD is easier to risk-stratify than it is to find at the right moment.

Gastroenterology and hepatology now have a growing set of non-invasive tools for fibrosis assessment, clearer risk-based care pathways, and an expanding treatment landscape for MASH with clinically significant fibrosis. Yet none of those advances matter if the patient enters the pathway only after fibrosis has already progressed.

The MDForLives survey examines that upstream problem from the specialist side. Clinicians were asked which patient groups drive their routine MASLD screening, what most often prevents earlier detection, which non-invasive test they use first, how confident they are in current NIT algorithms, where referrals come from, at what fibrosis stage patients typically arrive, how well gastroenterology, primary care, and endocrinology work together, and which system changes could accelerate diagnosis.

The most important pattern is a tension between visibility and timing. Metabolic-risk patients dominate screening, primary care generates most referrals, and NITs are already embedded in practice. Still, 58.1% say F2 is the most common stage at specialist presentation. The report therefore asks where an apparently well-recognized risk pathway is still losing time.

> **Survey lens.** MDForLives survey SGID 8935001 captured 45 survey records, including 31 complete responses and 14 partial responses, with a 68.9% completion rate across 5 countries: USA, UK, Italy, France, and Germany. Q4 has 32 responses; Q5–Q12 have 31 responses each. Q14 contains 20 visible open-ended responses. Internal operational, required-text validation, after-question, and honeypot fields are excluded from analysis.

CLINICAL CONTEXT

Current MASLD pathways are converging on risk-based case-finding and stepwise non-invasive fibrosis assessment.

The American Gastroenterological Association’s 2026 MASLD clinical care pathway identifies fibrosis as the key predictor of outcomes and notes that clinically significant risk begins at F2. It recommends focusing case-finding on adults with type 2 diabetes, people who are overweight or obese with additional metabolic risk, and patients with incidental steatosis or elevated liver enzymes. The pathway uses a two-tier strategy: simple fibrosis assessment such as FIB-4 first, followed by liver-stiffness measurement, commonly VCTE/FibroScan, or an alternative validated second-tier test when risk is elevated.

The 2024 EASL-EASD-EASO guideline similarly recommends case-finding for MASLD with fibrosis in people with cardiometabolic risk factors, abnormal liver enzymes, or radiological steatosis, particularly in type 2 diabetes or obesity with additional metabolic risk. At the same time, treatment options are changing. The FDA approved resmetirom in 2024 for noncirrhotic MASH/NASH with F2–F3 fibrosis, and in 2025 approved semaglutide for adults with MASH and moderate-to-advanced fibrosis.

That external context raises the stakes of the survey findings. Earlier fibrosis classification is no longer only about predicting future liver risk. It increasingly affects monitoring intensity, specialist referral, and whether a patient can be considered for disease-directed therapy.

External clinical context is provided for interpretation. MDForLives survey findings remain the source for all respondent percentages in this report.

EXECUTIVE SUMMARY

Six findings that explain why MASLD can still be detected later than the tools should allow.

INSIGHT 01

F2 is the modal specialist presentation

58.1% Most respondents say MASLD patients most commonly reach their gastroenterology/hepatology practice with moderate/significant fibrosis rather than F0–F1 disease.

INSIGHT 02

Silent disease is the leading detection barrier

54.8% The asymptomatic nature of early MASLD is selected far more often than under-recognition, pathway gaps, NIT cost, or patient misperception.

INSIGHT 03

Primary care is the main referral gateway

80.6% The specialist pathway depends heavily on how primary care identifies risk, orders first-line assessment, and interprets when referral is needed.

INSIGHT 04

NIT confidence is centered on 'moderate'

41.9% Current algorithms are clearly trusted enough to use, but confidence is not concentrated at the highest level.

INSIGHT 05

Elastography access is the top near-term system lever

35.5% Wider availability and reimbursement for transient elastography outrank referral guidelines, automated FIB-4, education, and public awareness.

INSIGHT 06

Therapies are expected to reshape the next phase

38.7% Approved disease-modifying pharmacological therapies lead AI prediction and novel plasma biomarkers as the expected three-to-five-year change.

01

SCREENING FOCUS

The MASLD screening workload is being pulled toward obesity and metabolic syndrome

68.8% say this group represents the highest volume of routine MASLD screening.

CONTEXT

The metabolic overlap of MASLD means liver-risk identification frequently begins outside a liver-specific complaint. For gastroenterology and hepatology, the composition of the screening pool matters because it determines where upstream case-finding needs to be reliable.

WHAT THE DATA SHOWS

Among 32 responses, 68.8% (22) identify patients with obesity or metabolic syndrome as their highest-volume routine MASLD screening cohort. Patients with incidental ALT/AST elevation account for 18.8% (6), while patients with type 2 diabetes mellitus account for 12.5% (4).

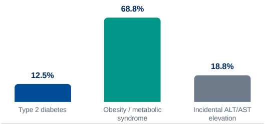
THE INSIGHT

The screening workload is anchored in visible metabolic risk rather than incidental biochemical abnormalities alone. This is important because obesity and metabolic syndrome are common, longitudinal conditions. They create repeated opportunities for fibrosis risk assessment, but they also create the possibility that liver risk is normalized as just one more item in a crowded metabolic problem list.

WHY IT MATTERS

If the largest screening cohort is already recognizable through metabolic phenotype, earlier detection depends less on discovering hidden risk factors and more on converting known risk into a consistent fibrosis-assessment trigger. The specialist pathway starts long before referral, inside routine diabetes, obesity, cardiovascular, and primary-care encounters.

Highest-volume cohort in routine MASLD screening



02

EARLY-DETECTION BARRIER

The leading barrier is biologic silence, which makes workflow the trigger for diagnosis

54.8% name the asymptomatic nature of early-stage liver disease as the single greatest barrier.

CONTEXT

Early MASLD and early fibrosis may not create symptoms that prompt a patient to seek care or a clinician to escalate liver-specific evaluation. That makes structured case-finding particularly important in high-risk metabolic populations.

WHAT THE DATA SHOWS

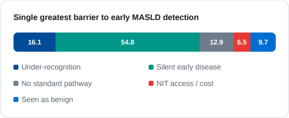
Of 31 respondents, 54.8% (17) select asymptomatic early-stage liver disease as the greatest barrier to early MASLD detection. Under-recognition and lack of routine screening in primary care follows at 16.1% (5), lack of standardized clinical screening pathways at 12.9% (4), patient belief that fatty liver is benign at 9.7% (3), and limited availability or high cost of NITs at 6.5% (2).

THE INSIGHT

The dominant barrier is not framed as a lack of available technology. It is the absence of a symptom-driven reason to act. In that environment, the system has to manufacture urgency through risk flags, routine calculations, pathway prompts, or deliberate case-finding.

WHY IT MATTERS

A silent disease makes inconsistency costly. If one practice calculates fibrosis risk routinely and another waits for symptoms or persistent enzyme abnormalities, patients with similar metabolic risk can enter specialist care at very different stages. The survey points toward workflow standardization as the practical counterweight to biologic silence.


Single greatest barrier to early MASLD detection

03

FIRST-LINE NIT

Elastography and simple serum scoring are competing as the first door into fibrosis assessment

38.7% start most often with transient elastography, versus 35.5% with a simple serum-based calculation.

CONTEXT

Current care pathways often describe a stepwise approach to non-invasive fibrosis risk stratification. In everyday practice, however, the first test depends on local access, workflow, referral setting, and clinician preference.

WHAT THE DATA SHOWS

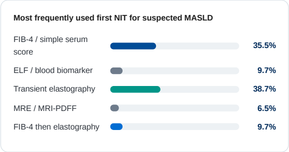
Transient elastography is the most frequently used first step for 38.7% (12) of respondents. Simple serum-based calculations such as FIB-4 or NAFLD Fibrosis Score follow closely at 35.5% (11). Specialized blood-based biomarker panels and sequential FIB-4 followed by transient elastography are each 9.7% (3), while MRE/MRI-PDFF is 6.5% (2).

THE INSIGHT

The first-line pathway is genuinely split. That can reflect different clinical settings rather than poor practice, but it also means patients may move through very different diagnostic sequences before reaching the same fibrosis-stage question.

WHY IT MATTERS

Consistency matters because the first test is not merely diagnostic. It determines who is reassured, who is retested, who receives second-tier assessment, and who is referred. A pathway that is easy to execute in primary care may need different tools from a pathway beginning inside specialist hepatology, but the thresholds connecting those settings still have to line up.


Most frequently used first NIT for suspected MASLD

04

CONFIDENCE IN NIT

Non-invasive algorithms are trusted, but not with the certainty of a closed diagnostic question

41.9% are moderately confident in current NIT algorithms for identifying at-risk MASH/fibrosis.

CONTEXT

NIT pathways are designed to reduce unnecessary biopsy and make fibrosis risk stratification scalable. Their practical value depends not only on test performance but also on whether clinicians trust the result enough to change follow-up, refer, or escalate evaluation.

WHAT THE DATA SHOWS

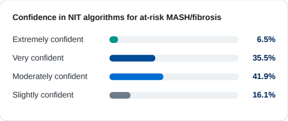
Among 31 respondents, 41.9% (13) are moderately confident, 35.5% (11) very confident, 16.1% (5) slightly confident, and 6.5% (2) extremely confident in current NIT algorithms for identifying at-risk MASH/fibrosis (F2–F3).

THE INSIGHT

Confidence is positive but calibrated. Most respondents sit in the moderate-to-very-confident range, while very few choose the highest-confidence category. That suggests NITs are functioning as decision tools rather than unquestioned answers, with clinical context and confirmatory assessment still shaping judgement.

WHY IT MATTERS

When confidence is measured rather than absolute, pathway design should reduce ambiguity around what happens after an intermediate or discordant result. Clear next-step rules can make an imperfect but useful test more actionable and reduce variation between clinicians or settings.



Confidence in NIT algorithms for at-risk MASH/fibrosis

05

REFERRAL ORIGIN

Primary care is the dominant gateway into specialist MASLD evaluation

80.6% say primary care or general practice generates the majority of MASLD referrals.

CONTEXT

MASLD often sits across primary care, endocrinology, cardiology, obesity medicine, and gastroenterology. The specialty that generates the referral therefore reveals where specialist access is most dependent on upstream recognition and triage.

WHAT THE DATA SHOWS

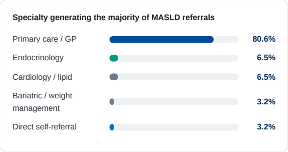
Primary care/general practice is selected by 80.6% (25) of respondents. Endocrinology/diabetology and cardiology/lipid clinics each account for 6.5% (2). Bariatric surgery/weight-management clinics and direct patient self-referrals are each 3.2% (1).

THE INSIGHT

The referral pathway is overwhelmingly primary-care dependent. Even if other metabolic specialties identify substantial MASLD risk, they are not the main source of specialist referrals in this cohort.

WHY IT MATTERS

This concentrates both opportunity and vulnerability in one handoff. If primary care has easy access to first-tier scoring, clear thresholds for second-tier testing, and straightforward referral criteria, the pathway can scale. If those steps are inconsistent, gastroenterology sees the downstream consequence regardless of how advanced specialist diagnostics become.



Specialty generating the majority of MASLD referrals

06

STAGE AT PRESENTATION

The modal referral arrives at F2, the point where fibrosis becomes clinically consequential

58.1% say patients most commonly present with moderate/significant fibrosis (F2).

CONTEXT

Fibrosis stage is the central risk variable in MASLD and increasingly influences follow-up intensity and treatment consideration. The stage at which patients first arrive in gastroenterology or hepatology therefore acts as a real-world readout of how early the upstream pathway is working.

WHAT THE DATA SHOWS

Of 31 respondents, 58.1% (18) say patients most commonly present at F2. Early steatosis without significant fibrosis (F0–F1) is selected by 22.6% (7), advanced fibrosis (F3) by 16.1% (5), and 3.2% (1) report no typical presentation pattern.

THE INSIGHT

The most common specialist presentation is neither the earliest stage nor the most advanced. It is the clinically meaningful middle, where fibrosis has already become established. That may represent successful interception before F3, but it also means the majority pattern is not truly early specialist involvement.

WHY IT MATTERS

AGA's 2026 pathway emphasizes F2 or higher as clinically significant risk, and regulatory treatment options now specifically include patients with moderate-to-advanced fibrosis. The survey therefore turns 'earlier detection' from an abstract prevention goal into a staging question: can the pathway identify and classify risk before F2 becomes the typical referral destination?

Most common MASLD stage at specialist presentation

22.6% F0–F1 early steatosis	**58.1%** F2 moderate/significant fibrosis
16.1% F3 advanced fibrosis	**3.2%** No typical pattern

07

MULTIDISCIPLINARY COLLABORATION

Cross-specialty collaboration is present, but formal operating rules are still missing

54.8% rate collaboration as good while explicitly noting the lack of formalized clinical protocols.

CONTEXT

MASLD is metabolically rooted but hepatologically staged. That makes collaboration between gastroenterology/hepatology, primary care, and endocrinology a structural requirement rather than an optional feature of complex cases.

WHAT THE DATA SHOWS

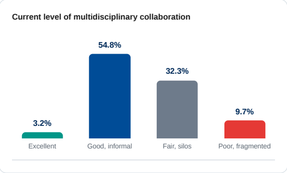
Among 31 respondents, 54.8% (17) rate collaboration as good but lacking formalized protocols. Another 32.3% (10) rate it fair because communication occurs while referral silos persist. Only 3.2% (1) describe well-established integrated pathways, while 9.7% (3) call care poor and fragmented.

THE INSIGHT

The field is not starting from zero. Communication exists. What appears to be missing is the conversion of professional goodwill into shared rules for risk stratification, referral, feedback, and ownership.

WHY IT MATTERS

Informal collaboration can work well for familiar colleagues and straightforward cases, but it is difficult to scale. Standardized protocols create continuity when patients move between clinicians, health systems, or levels of care, especially when the patient is asymptomatic and the urgency has to come from the pathway rather than symptoms.


Current level of multidisciplinary collaboration

08

NEAR-TERM SYSTEM LEVER

Clinicians want easier access to staging and clearer referral rules before another awareness campaign

35.5% choose wider availability and reimbursement for transient elastography as the single most effective initiative.

CONTEXT

The survey asked respondents to choose one system-level change that would most effectively accelerate early diagnosis and management globally. That forces a trade-off between technology access, workflow automation, referral standardization, professional education, and public awareness.

WHAT THE DATA SHOWS

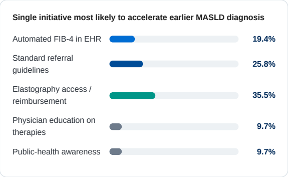
Widespread availability and reimbursement for transient elastography leads at 35.5% (11). Clear standardized inter-specialty referral guidelines follow at 25.8% (8), automated FIB-4 calculation inside primary-care EHRs at 19.4% (6), broader physician education about emerging MASH therapies at 9.7% (3), and targeted public-health awareness at 9.7% (3).

THE INSIGHT

Respondents prioritize making the diagnostic pathway executable. The top three answers all reduce friction between risk recognition and fibrosis classification: access to elastography, referral rules, and automatic first-tier scoring.

WHY IT MATTERS

Awareness is valuable, but awareness without a next step can create more recognized risk without faster resolution. The survey suggests that the more immediate need is infrastructure that turns recognition into action and communicates where each clinician's responsibility begins and ends.



Single initiative most likely to accelerate earlier MASLD diagnosis

09

THREE-TO-FIVE-YEAR HORIZON

The next MASLD shift is expected to come from treatment and prediction, not digital self-management

38.7% expect disease-modifying pharmacological therapies to have the greatest impact over the next three to five years.

CONTEXT

The management landscape is moving beyond lifestyle advice and risk observation alone. Approved therapies, predictive analytics, and biomarker development are changing what clinicians may be able to do once at-risk disease is found.

WHAT THE DATA SHOWS

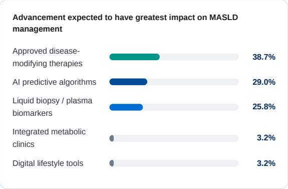
Disease-modifying pharmacological therapies lead at 38.7% (12), followed by AI-driven predictive algorithms using routinely collected clinical and laboratory data at 29.0% (9), and high-accuracy liquid biopsy or plasma biomarkers at 25.8% (8). Expansion of integrated multi-specialty metabolic clinics and direct-to-consumer digital health tools are each 3.2% (1).

THE INSIGHT

Respondents expect the largest gains from interventions that change what happens after risk is identified: effective therapy, better prediction, and more precise biomarkers. Digital self-management and clinic-structure expansion are not viewed as the leading transformation in this forced-choice question.

WHY IT MATTERS

A more powerful treatment and prediction era makes earlier pathway performance more important, not less. If patients are identified late or referral is inconsistent, the benefit of new tools may remain concentrated among those who successfully navigate the existing system. The future technology story therefore depends on the present implementation story.



Advancement expected to have greatest impact on MASLD management

OPEN-ENDED PERSPECTIVE

When clinicians describe the one change they want, they keep returning to earlier recognition, easier staging, and an actionable next step.

Twenty visible open-ended responses answered the question: “What is the single most important change needed in clinical practice to prevent MASLD patients from progressing to advanced liver disease?” The comments were reviewed thematically without assigning percentages or forcing every response into one category.

Earlier detection & screening

Multiple responses call for earlier recognition, screening of at-risk patients, or earlier intervention before disease becomes advanced.

Primary-care education & guidelines

Several clinicians ask for better education in general practice and clearer society-backed guidance so screening and management become routine upstream.

Lifestyle & patient education

Diet, physical activity, weight loss, patient motivation, and patient education recur as practical components of preventing progression.

Treatment access & tolerability

Comments call for affordable medication, better-tolerated oral options, and earlier treatment, reflecting concern about what happens after disease is identified.

Fibrosis staging access

One respondent explicitly asks for ubiquitous FibroScan, while another calls for better and easier staging, reinforcing the quantitative emphasis on access to fibrosis assessment.

Public-health recognition

Responses also mention broader recognition of MASH/fatty liver and public-health prevention, showing that some clinicians still see awareness as part of the solution even though it ranked lower in the forced-choice question.

> **What the qualitative comments add:** the closed questions emphasize silent disease, referral structure, and access to elastography. The open text makes the same problem more human: clinicians want primary care to recognize risk earlier, patients to understand the disease, fibrosis to be easier to stage, and effective treatment to be available soon enough to change the trajectory.

PEOPLE ALSO ASK

Frequently asked questions about MASLD screening and fibrosis risk.

What is MASLD and how is it different from MASH?

MASLD is metabolic dysfunction-associated steatotic liver disease, a broad diagnosis that includes hepatic steatosis in people with cardiometabolic risk factors. MASH is the inflammatory, potentially progressive form in which steatosis is accompanied by hepatocellular injury and can progress through fibrosis to cirrhosis.

Who should be assessed for fibrosis risk in MASLD?

Current pathways emphasize case-finding in higher-risk groups rather than indiscriminate population screening. These groups include adults with type 2 diabetes, people with overweight or obesity plus additional metabolic risk, and patients with incidental steatosis or unexplained liver-enzyme elevation.

What is FIB-4 and how is it used in MASLD?

FIB-4 is a simple blood-based fibrosis risk score calculated from age, AST, ALT, and platelet count. It is commonly used as a first-tier test to identify people who can remain in lower-risk follow-up and those who need a second non-invasive assessment.

When is transient elastography or FibroScan used in MASLD?

Transient elastography is commonly used as a second-tier test when first-line fibrosis assessment suggests increased risk, or when clinical context warrants more direct liver-stiffness measurement. It helps refine who may need hepatology evaluation, monitoring, or treatment planning.

What does F2 fibrosis mean in MASLD?

F2 indicates moderate or clinically significant fibrosis. Current MASLD pathways treat F2 or higher as an important risk threshold because liver-related risk rises as fibrosis advances and treatment decisions increasingly depend on accurate staging.

Are there approved medicines for MASH with moderate to advanced fibrosis?

Yes. Regulatory options have expanded. In the United States, resmetirom was approved in 2024 for noncirrhotic MASH/NASH with F2–F3 fibrosis, and semaglutide received an FDA MASH indication in 2025 for adults with moderate-to-advanced fibrosis. Local approvals, eligibility, and prescribing information should always be checked.

GASTROENTEROLOGY & HEPATOLOGY PRACTICE LENS

What this means at four points in the MASLD pathway.

The survey does not argue for one universal workflow across every health system. It does identify four points where pathway clarity can determine whether risk turns into timely staging and specialist action.

At risk identification

Screening lens. The survey places obesity and metabolic syndrome at the center of routine MASLD screening. A practical pathway has to make fibrosis risk assessment a repeatable part of metabolic care rather than an exception triggered only by symptoms.

At first-line assessment

NIT lens. FIB-4 and transient elastography are both common entry points in this cohort. The important operational question is not which tool 'wins,' but whether the sequence and thresholds are clear across the settings that share the patient.

At referral

Handoff lens. Primary care generates 80.6% of referrals, while F2 is the most common stage at specialist presentation. Shared referral rules and feedback loops may be more scalable than informal clinician-to-clinician coordination alone.

At treatment planning

Fibrosis-stage lens. As disease-directed therapies expand for MASH with moderate-to-advanced fibrosis, accurate staging becomes more tightly connected to treatment eligibility, monitoring, and the value of identifying disease before progression.

CLOSING PERSPECTIVE

The MASLD gap is no longer simply knowing who is at risk. It is getting risk to become action early enough.

Across the survey, the same pathway tension appears from several directions. Obesity and metabolic syndrome dominate screening. Early disease is often silent. Primary care generates most referrals. Clinicians use non-invasive tests but differ on the first step and express calibrated rather than absolute confidence. Collaboration is usually described as good, yet formal protocols remain uncommon. And the most common specialist presentation is already F2.

The encouraging part is that respondents do not describe an unsolvable diagnostic problem. They point to practical levers: make transient elastography easier to access, standardize referral guidance, automate first-tier fibrosis scoring, educate clinicians about the changing treatment landscape, and improve awareness where it still blocks recognition. Open-ended comments reinforce the same themes with calls for earlier screening, easier staging, better primary-care education, lifestyle support, and accessible treatment.

The timing matters because the therapeutic context has changed. Moderate-to-advanced fibrosis is now directly relevant to approved MASH treatment options, and clinicians expect disease-modifying therapies, AI prediction, and novel biomarkers to shape the next three to five years. Better technology will increase the value of a well-designed pathway, but it will not compensate for a patient who never reaches the right test or specialist in time.

The larger story is therefore one of implementation. MASLD risk is increasingly visible. The challenge is to make the response to that risk predictable across specialties, so that a silent disease is not allowed to become a late referral simply because no one step in the pathway felt urgent on its own.

1 · Make metabolic risk a repeatable trigger

Define when obesity, type 2 diabetes, metabolic syndrome, elevated enzymes, or incidental steatosis should lead to fibrosis risk assessment rather than passive observation.

2 · Make first-tier scoring easy to execute

Use routine clinical and laboratory data efficiently so FIB-4 or another validated first-tier tool does not depend on a separate specialist encounter.

3 · Protect access to second-tier staging

Reduce practical friction around transient elastography, ELF, or other validated second-tier tests when first-tier risk is elevated or uncertain.

4 · Standardize referral thresholds

Create shared expectations for when primary care, endocrinology, cardiology, or obesity services should refer and what information should accompany that referral.

5 · Close the specialist feedback loop

Return a clear risk category, monitoring interval, and responsibility plan so the patient does not fall back into an undefined shared-care space.

6 · Connect earlier detection to treatment readiness

As MASH therapies and predictive tools expand, align staging pathways with the patients most likely to benefit from timely specialist assessment and treatment consideration.

Help future MASLD insights reflect what happens before and after referral.

Share your gastroenterology or hepatology perspective with MDForLives and help build a clearer view of screening, fibrosis staging, treatment, and cross-specialty care in real-world practice.

Join the Panel

Sources used for this report

1. **MDForLives Gastro Insight Survey_Aug, SGID 8935001.** Source survey report: 45 records, 31 complete responses, 14 partial responses, 68.9% completion rate; country distribution and Q4–Q12 values extracted from the supplied PDF. Q14 open-ended responses were interpreted qualitatively without percentage coding.
2. **American Gastroenterological Association.** Clinical care pathway for the risk stratification and management of patients with MASLD. Published March 9, 2026. https://gastro.org/clinical-guidance/clinical-care-pathway-for-the-risk-stratification-and-management-of-patients-with-masld/
3. **EASL-EASD-EASO.** Clinical Practice Guidelines on the management of metabolic dysfunction-associated steatotic liver disease (MASLD). Journal of Hepatology. 2024;81(3):492–542. PMID: 38851997.
4. **U.S. Food and Drug Administration.** FDA Approves First Treatment for Patients with Liver Scarring Due to Fatty Liver Disease. March 14, 2024. Resmetirom approved for adults with noncirrhotic NASH/MASH with moderate-to-advanced fibrosis.
5. **U.S. Food and Drug Administration.** FDA Approves Treatment for Serious Liver Disease Known as MASH. 2025. Semaglutide approved for adults with MASH and moderate-to-advanced fibrosis.
6. **American Association for the Study of Liver Diseases.** Clinical Assessment and Management of Metabolic Dysfunction-Associated Steatotic Liver Disease, including 2024 resmetirom and 2025 semaglutide practice-guidance updates.

External sources provide clinical and regulatory context only. All MDForLives respondent percentages and counts in this report come from the supplied survey data.

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