through the Delphi process, the following guidance statements were generated (Figure 2). First, the treatment goal for healthy lifestyle intervention is a reduction of body weight by ≥5% (3%–5% in persons with a normal or lean BMI) to reduce liver fat, body weight reduction of 7% to 10% to decrease liver inflammation, and body weight loss ≥10% to reduce fibrosis.[8,19] To achieve these weight-loss goals, a healthy diet (such as the Mediterranean dietary pattern or a similar plant-based diet) should be recommended, with an emphasis on increased consumption of fruits, vegetables, legumes (eg, lentils, beans, chickpeas, green peas, soybeans), nuts, olive oil, and unprocessed poultry and fish. Ultra-processed foods, saturated fat, sugar-sweetened beverages, and foods with added fructose (found in industrialized processed foods) should be avoided or limited. In addition, decreasing sedentary time is recommended by increasing daily activity and performing 150 to 300 minutes of moderate activity or 75 to 150 minutes of vigorous activity each week. Individuals should also be encouraged to stop smoking and minimize alcohol consumption, especially for those with advanced liver disease. Consideration should also be given to the provision of access to structured lifestyle behavioral programs, psychological and social support when needed, and the measurement of health-related quality of life.

Treatment of metabolic comorbidities with existing medications. As noted, it is widely recommended that cardiometabolic risk factors be evaluated, according to their respective cardiometabolic guidelines,[15,16,20,21] regardless of availability of MASH-specific treatment. After the Delphi process, recommendations were proposed to assist caregivers in selection of therapies for the treatment of cardiometabolic risk factor in individuals with MASLD or MASH (Table 3, Supplementary Tables 6 and 8).

Bariatric and metabolic surgery. In the guideline review, there was high concordance among recommendations for bariatric surgery for weight-loss management among patients with MASH without cirrhosis. However, given the invasiveness of this procedure, a Delphi statement was generated and achieved an 85% agreement in the first round (Table 3, Supplementary Table 6). In this context, the consensus is that bariatric surgery should be considered as part of weight-loss management for people with non-cirrhotic MASH who meet the criteria for this type of surgery. However, bariatric surgery is not specifically recommended for the treatment of MASH; recommendations for patients to undergo bariatric surgery should follow current approved indications.

Drug treatment specific to MASH. Although some guidelines proposed vitamin E supplementation (800 IU per day) for treatment of MASH, the most recent guidelines did not recommend its use or suggested its use in limited cases among patients without T2D or cirrhosis.[15,16] Furthermore, based on review of guidelines, ursodeoxycholic acid or omega-3 fatty acids should not be considered as treatments for MASH (Table 3, Supplementary Tables 6 and 8). Previous guidelines have limited the use of pioglitazone for treatment of T2D among individuals with MASLD. Most glucagon-like peptide-1 receptor agonists (GLP-1RAs) have been recommended for treatment of T2D and obesity in individuals with MASLD, but not specifically as MASH-targeted therapies.[20,21] Nevertheless, there are data from phase 2 and 3 clinical trials reporting liver benefits from GLP-1RAs in patients with MASH. In a 3 phase trial of subjects with MASH and F2 or F3, almost 62.9% of those treated with semaglutide achieved resolution of steatohepatitis with no worsening of liver fibrosis, compared with 34.3% of subjects receiving placebo. Furthermore, a reduction in liver fibrosis without worsening of steatohepatitis was reported in 36.8% of the patients in the semaglutide group and in 22.4% of those in the placebo group ($P < .001$).[22] Once GLP-1RAs are approved and available for treatment of MASH, guidelines will be revised accordingly. Pioglitazone and other antidiabetic drugs have not been recommended specifically for treatment of MASH, but they are important for management of T2D in patients with MASH.[20,21] The guideline from India (Indian National Association for Study of the Liver) mentions saroglitazar as an approved treatment for MASH in India.[11]

Treatment of MASH with an approved THR-β agonist (resmetirom). In March of 2024, a novel THR-β agonist, resmetirom, was approved by the FDA for treatment of MASH in patients with F2–F3.[18,23] Although the FDA approval was based on histologic endpoints, treatment with this drug does not require MASH confirmation by liver biopsy. NITs are sufficient for diagnosis of MASH and monitoring the effects of resmetirom. As a part of the Delphi process, 14 statements related to resmetirom were selected to assist in the development of an algorithm.

Although all 14 statements achieved at least 70% agreement (the lowest agreement was 71%, for the Delphi statement "improvement in the liver biochemical profile is a principal indicator of treatment success"), numerous comments were received and deemed important for inclusion in the second through fourth rounds of the Delphi process. The second survey included 8 statements, which all achieved >80% agreement. However, 5 statements had 52% to 64% response rates for "Agree"; these 5 statements were reviewed with GNC experts, and an approval of at least 80% "Agree" was obtained.

After this step, 9 statements were generated to guide the administration and monitoring of resmetirom, covering treatment initiation, which NITs to use, and monitoring response to therapy.[18,22–24] These 9 statements were used in the third round of the Delphi process. Again, although all statements achieved >80% agreement, many comments were received during the Delphi process, which were used to generate 6 statements for the fourth round of the Delphi process. After the fourth round, all 6 statements achieved >80% agreement. Although some comments remain, there is insufficient scientific evidence and long-term clinical experience to refine the statements further. Additional research is needed to provide more clarity on resmetirom treatment and monitoring in patients with MASH (Supplementary Tables 6, 8, 11, and 13).

The review of the Delphi processes regarding treatment and monitoring of resmetirom is summarized in Table 3 and Figure 3. Briefly, diagnoses of MASH with F2 and F3 are