International Journal of Community Medicine and Public Health
Gani ABMS et al. Int J Community Med Public Health. 2026 Nov;13(11):6302-6308
https://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20264048

Original Research Article

Comparison of ALBI, PALBI, MELD and Child-Pugh scores in chronic liver disease: evidence from Bangladesh

A. B. M. Shakil Gani[1]*, Uzzal Kanti Debnath[1], M. Sabbir Hossain[1], Nur Alam[1], Zannatul Habiba[1], Ankita Banik[1], Rebeka Sultana Mousumi[1], Sourav Kumar Saha[1], Ihteshamul Hoq Dew[1], Forhad Hossain Md Shahed[1], Tasnim Mahmud[2]

[1]Department of Hepatology, Dhaka Medical College Hospital, Dhaka, Bangladesh
[2]Department of Public Health, North South University, Dhaka, Bangladesh

Received: 15 May 2026
Revised: 22 September 2026
Accepted: 26 September 2026

***Correspondence:**
Dr. A. B. M. Shakil Gani,
E-mail: abmshakilgani@gmail.com

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ABSTRACT

Background: Accurate assessment of hepatic reserve is essential for prognosis in chronic liver disease (CLD). This study aimed to evaluate the correlation of ALBI and PALBI scores with MELD and Child-Turcotte-Pugh (CTP) scores and compare their predictive value in Bangladeshi patients with CLD of mixed etiologies.
Methods: A cross-sectional study was conducted among 105 patients with established CLD. Clinical and laboratory data were collected to calculate ALBI, PALBI, MELD, and CTP scores. Correlations were assessed using Spearman's rank test, while hierarchical linear regression evaluated the independent predictive contribution of ALBI and PALBI.
Results: ALBI and PALBI showed significant positive correlations with MELD (ρ=0.539 and 0.625, respectively; $p<0.001$) and CTP (ρ=0.721 and 0.679, respectively; $p<0.001$). Age was not significantly associated with MELD or CTP scores. PALBI showed a stronger predictive contribution for MELD (ΔR^2=0.085, $p<0.001$), whereas ALBI demonstrated greater unique contribution to CTP (ΔR^2=0.054, p=0.001).
Conclusions: ALBI and PALBI are simple, objective, and economical indices that correlate well with conventional liver severity scores. PALBI better reflects MELD-related systemic components, while ALBI more closely represents hepatic functional reserve.

Keywords: ALBI, Child-Pugh, Hepatic reserve, MELD, PALBI

INTRODUCTION

Chronic liver disease (CLD) is a major global health concern and a leading cause of morbidity and mortality worldwide, with a particularly high burden in Asia. The Asia- Pacific region accounts for more than half of global CLD-related deaths due to the high prevalence of chronic viral hepatitis, alcohol-related liver disease, and the rising incidence of metabolic-associated fatty liver disease.[1,2] South Asia, including Bangladesh, remains heavily affected, where hepatitis B virus (HBV) infection is the predominant etiology of cirrhosis and its complications.[3,4] Limited access to early diagnosis, delayed presentation, and resource constraints further compound disease severity in this setting. Consequently, reliable and objective assessment of hepatic functional reserve is essential for prognostication, clinical decision-making, and prioritization of care.

Several scoring systems have been developed to evaluate disease severity and predict outcomes in patients with cirrhosis. The Child-Turcotte-Pugh (CTP) score has been used for decades because of its simplicity and ability to classify cirrhosis into prognostic categories.[5] However, the inclusion of subjective parameters such as ascites and hepatic encephalopathy introduces inter-observer variability and limits reproducibility.[6] The model for end-stage liver disease (MELD) score was introduced as a

more objective alternative, based on serum bilirubin, creatinine, and international normalized ratio, and is now widely used for prognostication and liver transplant allocation.[7] Despite its utility, MELD is influenced by renal dysfunction and anticoagulant use and may not fully reflect intrinsic hepatic reserve, particularly in patients with stable or compensated cirrhosis.[8]

To address these limitations, newer prognostic indices relying solely on objective biochemical variables have been proposed. The Albumin-Bilirubin (ALBI) score was developed to provide a simple and reproducible assessment of liver function using only serum albumin and bilirubin levels.[9] ALBI has demonstrated good prognostic performance in patients with chronic liver disease and hepatocellular carcinoma and avoids the subjectivity inherent in traditional scores.[10] Subsequently, the Platelet-Albumin-Bilirubin (PALBI) score was introduced by incorporating platelet count as a surrogate marker of portal hypertension, thereby aiming to improve prognostic accuracy while maintaining objectivity.[11] Both ALBI and PALBI scores are calculated from routinely available laboratory parameters, making them particularly suitable for use in low-resource healthcare settings across Asia.

Studies from East and Southeast Asia have shown significant correlations between ALBI and PALBI scores and established models such as MELD and CTP, as well as associations with clinical outcomes including mortality and hepatic decompensation.[12,13] These findings suggest that ALBI and PALBI may serve as practical alternatives or adjuncts to conventional scoring systems. However, the epidemiology of chronic liver disease varies widely across Asian populations in terms of etiology, age distribution, nutritional status, and disease progression.[14] Bangladesh represents a distinct clinical context, characterized by a predominance of HBV-related cirrhosis, younger age at presentation, and limited availability of specialized hepatology services.[3,15] Despite these differences, evidence validating the performance of ALBI and PALBI scores in Bangladeshi patients with chronic liver disease remains limited.

In Bangladesh, MELD and CTP scores continue to be the primary tools used to assess disease severity and guide management in patients with cirrhosis. Given the limitations of these conventional models and the potential advantages of ALBI and PALBI as simple, objective, and economical indices, it is important to evaluate their applicability and predictive value in this population. Emerging evidence suggests that ALBI may better reflect hepatic synthetic function, whereas PALBI may capture portal hypertensive and systemic components of advanced liver disease.[11,13] However, such relationships have not been adequately explored in Bangladeshi adults with chronic liver disease of mixed etiologies.

Therefore, the aim of this study was to evaluate the correlation of ALBI and PALBI scores with conventional MELD and Child-Turcotte-Pugh scores and to compare their predictive value in Bangladeshi patients with chronic liver disease of mixed etiologies.

METHODS

This hospital-based cross-sectional analytical study entitled "comparison of ALBI, PALBI, MELD, and Child-Turcotte-Pugh scores in chronic liver disease: evidence from Bangladesh" was conducted from January 2024 to December 2024 in the department of hepatology, Dhaka Medical College Hospital (DMCH), Dhaka, Bangladesh. The study population comprised adult patients with established chronic liver disease attending the inpatient and outpatient services of the Department of Hepatology, DMCH. A total of 105 patients were enrolled consecutively during the study period. Patients aged ≥18 years with a diagnosis of chronic liver disease based on clinical features, biochemical parameters, and radiological findings, and with complete laboratory data required for calculation of ALBI, PALBI, MELD, and Child-Turcotte-Pugh scores, were included. On the other hand, Patients with acute liver failure or acute-on-chronic liver failure, hepatocellular carcinoma or other malignancies, previous liver transplantation, severe systemic illness (such as advanced cardiac failure or end-stage renal disease), or incomplete clinical or laboratory data were excluded.

Operational definitions[5,9]

Chronic liver disease was defined as progressive hepatic injury lasting more than six months. The Child-Turcotte-Pugh score was calculated using serum bilirubin, serum albumin, INR, presence of ascites, and hepatic encephalopathy. The MELD score was calculated using serum bilirubin, serum creatinine, and INR. The ALBI score was derived from serum albumin and bilirubin levels, while the PALBI score incorporated platelet count in addition to albumin and bilirubin, according to previously validated formulas.

Ethical considerations

Ethical approval was obtained from the Institutional Review Board of Dhaka Medical College. The study was conducted in accordance with the Declaration of Helsinki. Written informed consent was obtained from all participants. Confidentiality and anonymity of patient information were strictly maintained.

Data analysis

Data were entered and analyzed using Statistical Package for the Social Sciences (SPSS) version 26.0. Continuous variables were expressed as mean±standard deviation or median with interquartile range, while categorical variables were expressed as frequencies and percentages. Spearman's rank correlation test was used to assess correlations between ALBI and PALBI scores with

MELD and Child-Turcotte-Pugh scores. One-way analysis of variance was applied to evaluate associations between age groups and severity scores, and chi-square test was used for associations between age and etiology. Hierarchical linear regression analysis was performed to compare the independent predictive value of ALBI and PALBI scores. A p value <0.05 was considered statistically significant.

RESULTS

Table 1 Spearman's rank correlations demonstrated significant positive associations between the bilirubin-albumin-platelet-based indices and standard severity scores. ALBI correlated with MELD (ρ=0.539, p<0.001) and more strongly with Child-Pugh (CTP) (ρ=0.721, p<0.001). PALBI likewise correlated with MELD (ρ=0.625, p<0.001) and with CTP (ρ=0.679, p<0.001). The magnitudes indicate moderate-to-strong concordance, with the strongest alignment observed for ALBI-CTP. In contrast, MELD did not differ by etiological cause on one-way ANOVA (p=0.96), suggesting MELD was independent of aetiology in this cohort.

Mean MELD did not differ across age categories on one-way ANOVA (p=0.526). Likewise, Child–Pugh (CTP) scores showed no significant differences by age group (p=0.733). These findings indicate no detectable association between age category and either MELD or CTP in this cohort.

Table 1: Association of ALBI and PALBI score with MELD and CTP score (n=105).

Association between	Statistical test	Value of "r" (correlation coefficient)	P value	Association
ALBI Score versus MELD	Spearman's correlation	0.539 (positive correlation)	<0.001	Significant
ALBI Score versus CTP	Spearman's correlation	0.721 (positive correlation)	<0.001	Significant
PALBI Score versus MELD	Spearman's correlation	0.625 (positive correlation)	<0.001	Significant
PALBI Score versus CTP	Spearman's correlation	0.679 (positive correlation)	<0.001	Significant
Cause versus MELD	One-way ANOVA		0.96	Non-significant

Table 2: Association of age group with MELD and CTP score (n=105).

Association between	Statistical test	P value	Association
Age group versus MELD	One-way ANOVA	0.526	Non-significant
Age group versus CTP	One-way ANOVA	0.733	Non-significant

Table 3: Distribution of causes according to age group (n=105).

Age group	Hep B	Hep C	NBNC	NASH	Wilson	Hemochromatosis	Total
<20	0	0	1	0	1	1	3
21-30	9	0	1	0	0	0	10
31-40	14	0	0	0	0	0	14
41-50	24	4	6	0	0	0	34
51-60	16	5	1	0	0	0	22
61-70	11	4	3	2	0	0	20
>70	1	0	1	0	0	0	2

*Chi-square test: p value <0.001.

Table 3 the distribution of aetiological causes differed significantly across age categories ($\chi^2(30)$ =95.15, p<0.001; Cramér's V=0.43, indicating a moderate association). Inspection of adjusted standardized residuals showed that hepatitis B was more frequent than expected in the 31-40 years group, NASH clustered in 61-70 years, while rare causes such as Wilson disease and hemochromatosis were over-represented in <20 years. Overall counts by cause were: hepatitis B 75/105 (71.4%), hepatitis C 13/105 (12.4%), NBNC 13/105 (12.4%), NASH 2/105 (1.9%), Wilson 1/105 (1.0%) and hemochromatosis 1/105 (1.0%).

Figure 1 resembles the fitted linear line slopes upward: as ALBI rises toward 0 (worse liver function), MELD increases. Here R^2=0.242, so the linear model explains ~24% of MELD variation. That corresponds to r≈0.49 (moderate positive association). ALBI score showed a moderate positive association with MELD (R^2=0.24; r≈0.49), indicating higher (worse) ALBI values were associated with higher MELD scores.

Figure 2 ALBI score showed a moderate positive linear association with CTP (Figure 1). Less-negative (higher) ALBI values were associated with higher CTP totals, indicating concordant worsening of hepatic dysfunction.

The linear model explained 45.9% of the variance in CTP (R^2=0.459), with slightly greater dispersion at higher ALBI values, consistent with partial but not complete overlap between indices.

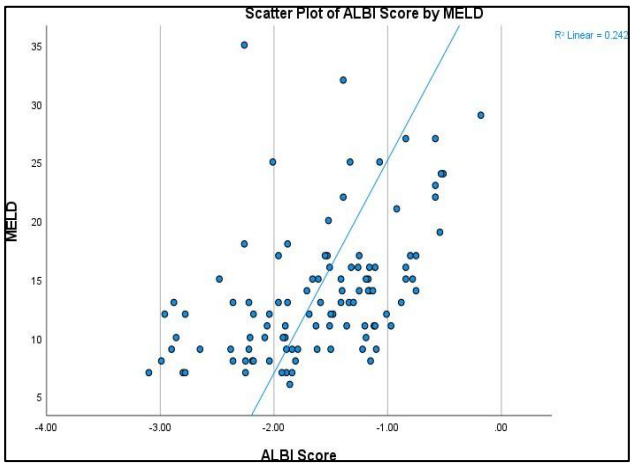


Figure 1: Scatterplot of ALBI score by MELD (n=105).

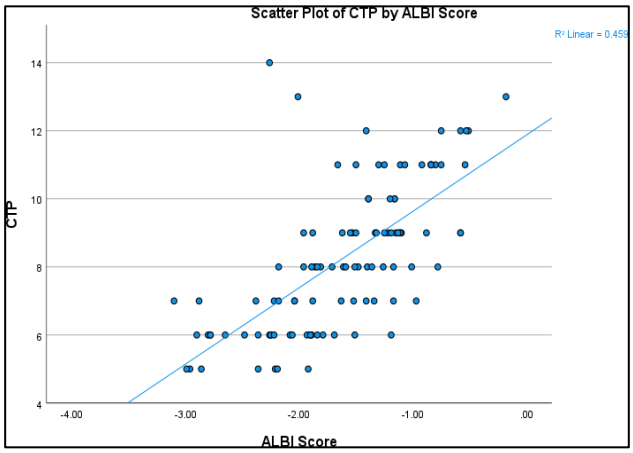


Figure 2: Scatterplot of ALBI score by CTP (n=105).

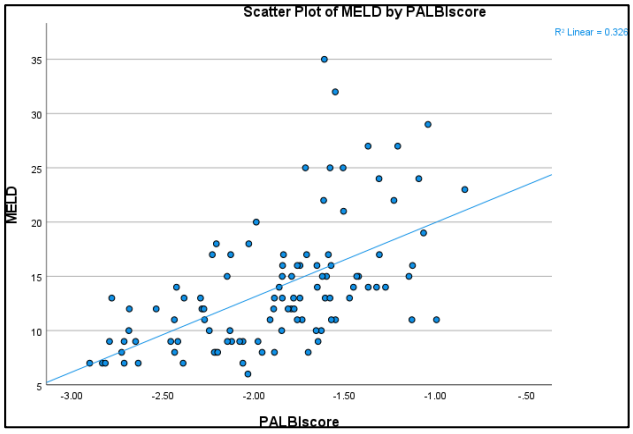


Figure 3: Scatterplot of PALBI score by MELD (n=105).

Figure 3 PALBI score demonstrated a modest positive linear association with MELD (Figure 2). Increasing (less-negative) PALBI values corresponded to higher MELD scores. The fitted model accounted for 32.6% of MELD variability (R^2=0.326), reflecting concordance but highlighting non-overlap- likely due to MELD's incorporation of renal function and coagulopathy components not included in PALBI.

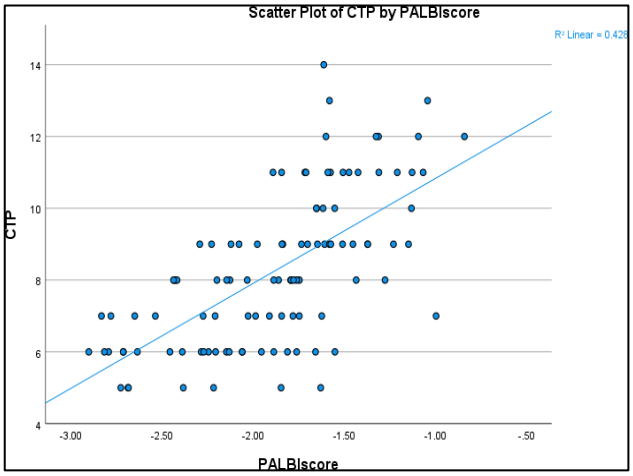


Figure 4: Scatterplot of ALBI score by CTP (n=105).

Figure 4 demonstrated a moderate positive linear association with CTP (Figure 4). Less- negative (higher) PALBI values were associated with higher CTP totals, indicating concordant worsening of hepatic dysfunction. The fitted linear model explained 42.8% of the variance in CTP (R^2=0.428), with some increased scatter at higher PALBI values, consistent with partial overlap but non-equivalence between indices.

Table 4 resembles hierarchical linear regression comparing PALBI vs ALBI as predictors of MELD and CTP. For MELD, ALBI alone explained 24.2% of variance (R^2=0.242; RMSE 4.99). Adding PALBI improved fit to R^2=0.327 (ΔR^2=0.085, F-change=12.79, p=0.00053); in the combined model PALBI was significant (β=6.47, 95% CI 2.88-10.07, p=0.00053) while ALBI was not (p=0.782). Reversing entry (PALBI first) showed no incremental gain from ALBI ($\Delta R^2 \approx 0.0005$, p=0.782) → PALBI outperforms ALBI for MELD.

For CTP, ALBI explained 45.9% (R^2=0.459; RMSE 1.58). Adding PALBI yielded a smaller but significant gain to R^2=0.484 (ΔR^2=0.025, F-change=5.00, p=0.0276); in the joint model both were significant (ALBI β=1.43, 95% CI 0.57-2.29, p=0.00141; PALBI β=1.31, 95% CI 0.15-2.47, p=0.0276). Entering PALBI first, ALBI provided a larger unique gain (ΔR^2=0.054, p=0.00141) → ALBI is the stronger unique contributor for CTP.

Table 4: Hierarchical linear regression comparing PALBI versus ALBI as predictors of MELD and CTP (n=105).

Outcome	Block / Model	R^2	ΔR^2 versus prior	F-change (p)	Key coefficient(s) in this block (β, 95% CI, p)	Notes
MELD (continuous)	1: ALBI only	0.242	—	—	—	RMSE 4.99
	2: ALBI + PALBI	0.327	0.085	12.79 (p=0.00053)	PALBI: β=6.47, 95% CI 2.88-10.07, p=0.00053; ALBI: β=0.37, p=0.782	RMSE 4.67 ↓
	1′: PALBI only	0.326	—	—	—	
	2′: PALBI + ALBI	0.327	0.0005	0.08 (p=0.782)	ALBI: β=0.37, 95% CI −2.29-3.04, p=0.782	No incremental gain
CTP (total score)	1: ALBI only	0.459	—	—	—	RMSE 1.58
	2: ALBI + PALBI	0.484	0.025	5.00 (p=0.0276)	PALBI: β=1.31, 95% CI 0.15-2.47, p=0.0276; ALBI: β=1.43, p=0.00141	RMSE 1.54 ↓
	1′: PALBI only	0.429	—	—	—	
	2′: PALBI + ALBI	0.484	0.054	10.78 (p=0.00141)	ALBI: β=1.43, 95% CI 0.57-2.29, p=0.00141; PALBI: β=1.31, p=0.0276	Larger unique gain from ALBI

DISCUSSION

This hospital-based cross-sectional analytical study was conducted over a one-year period among 105 adult patients with chronic liver disease attending the Department of Hepatology, Dhaka Medical College Hospital, Bangladesh. Using consecutive sampling, the study aimed to evaluate the relationship of two objective liver function scores- Albumin-Bilirubin (ALBI) and Platelet-Albumin-Bilirubin (PALBI)- with conventional prognostic models, namely the model for end-stage liver disease (MELD) and Child-Turcotte-Pugh (CTP) scores, in a Bangladeshi population with mixed etiologies of chronic liver disease. The primary motive was to determine whether ALBI and PALBI could serve as reliable, simple, and economical alternatives or adjuncts to traditional scoring systems in a resource-limited setting.

In the present study, both ALBI and PALBI scores demonstrated significant positive correlations with MELD and CTP scores, indicating moderate-to-strong concordance between these objective indices and established severity models. ALBI showed a moderate positive correlation with MELD and a stronger correlation with CTP, while PALBI exhibited significant correlations with both MELD and CTP. These findings are consistent with previous studies conducted in different clinical settings, which have reported that ALBI correlates well with traditional liver function scores and clinical outcomes in patients with cirrhosis and hepatocellular carcinoma.[9] The stronger association observed between ALBI and CTP in this study may be explained by the shared emphasis on hepatic synthetic function, particularly serum albumin and bilirubin, which are core components of both scores.

The observed correlation between PALBI and MELD was stronger than that between ALBI and MELD, a finding that aligns with earlier reports suggesting that PALBI may better capture the systemic and portal hypertensive aspects of advanced liver disease.11 MELD incorporates renal function and coagulation parameters, which are not included in ALBI but may be indirectly reflected in PALBI through platelet count as a marker of portal hypertension and hypersplenism. Similar findings have been reported in Asian cohorts, where PALBI demonstrated superior performance over ALBI in predicting short-term mortality and disease severity assessed by MELD.[17]

Hierarchical linear regression analysis further supported these observations. In the present study, PALBI emerged as the stronger independent predictor of MELD, providing a significant incremental contribution when added to ALBI, whereas ALBI did not add meaningful

predictive value once PALBI was included. This suggests that PALBI may better reflect the multidimensional severity captured by MELD, particularly in patients with advanced cirrhosis. Comparable results have been reported by Roayaie et al and subsequent validation studies, which showed that PALBI improves prognostic stratification beyond ALBI in advanced liver disease.[11,18]

Conversely, ALBI was found to be the stronger unique predictor of CTP score, explaining a larger proportion of variance compared with PALBI. This finding is biologically plausible, as ALBI focuses on hepatic synthetic and excretory function without the influence of portal hypertension-related variables. Prior studies have also demonstrated that ALBI closely parallels CTP grading and may serve as an objective alternative by eliminating subjective clinical parameters such as ascites and encephalopathy.[12,19] The current findings therefore reinforce the complementary nature of ALBI and PALBI, rather than suggesting the superiority of one score in all clinical contexts.

The present study also found no significant association between age groups and either MELD or CTP scores, indicating that disease severity, as assessed by these models, was independent of age in this cohort. Similar observations have been reported in other regional studies, suggesting that biochemical severity indices may be more reflective of disease stage than demographic characteristics.[8] However, the distribution of etiological causes differed significantly across age groups, with hepatitis B predominating overall and clustering in middle-aged adults. This pattern is consistent with epidemiological data from Bangladesh and neighboring South Asian countries, where chronic hepatitis B remains the leading cause of cirrhosis.[3,20] The lack of association between MELD and etiology observed in this study has also been reported previously, supporting the notion that MELD reflects physiological severity rather than underlying cause.[21]

Taken together, the findings of this study are in agreement with existing international and regional literature and extend current knowledge by providing locally generated evidence from Bangladesh. The demonstrated correlations and differential predictive strengths of ALBI and PALBI suggest that these scores may be useful adjuncts to conventional models in routine clinical practice. Their simplicity, objectivity, and reliance on readily available laboratory parameters make them particularly attractive for use in resource-constrained healthcare systems.

CONCLUSION

In Bangladesh, where hepatitis B-related cirrhosis is common and healthcare resources are limited, ALBI and PALBI scores provide practical, objective alternatives to conventional severity models. Their dependence on routinely available laboratory parameters makes them feasible, reproducible, and suitable for use in peripheral and resource-constrained settings. Routine application of these scores may improve disease stratification, follow-up, and clinical decision-making in patients with chronic liver disease. However, evidence from larger and more diverse populations is still required. Future multicenter, prospective studies should evaluate their prognostic accuracy across different etiologies and disease stages. Incorporation of ALBI and PALBI into national guidelines may contribute to more standardized and effective liver disease management in Bangladesh.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee of Dhaka Medical College

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Cite this article as: Gani ABMS, Debnath UK, Hossain MS, Alam N, Habiba Z, Banik A, et al. Comparison of ALBI, PALBI, MELD and Child-Pugh scores in chronic liver disease: evidence from Bangladesh. Int J Community Med Public Health 2026;13:6302-8.