

**Decompensated cirrhosis is a medical emergency with a high level of mortality. All patients should be reviewed by a Senior as soon as possible**

**Defined as patient with cirrhosis who presents with an acute deterioration in liver function**

## SIGNS & SYMPTOMS

- Jaundice
- Increasing ascites
- Hepatic encephalopathy
- Renal impairment

- UGI bleeding
- Hypovolemia
- Signs of sepsis

## COMMON CAUSES

**Frequently there is a precipitant and treatment should aim to address this as soon as possible**

- Alcoholic hepatitis
- Medications:
  - Alcohol / Opiates / NSAIDS
- Infection / Sepsis
- Dehydration

- GI bleeding
- Acute portal vein thrombus
- Hepatocellular carcinoma
- Ischaemic liver injury
- Constipation

## INVESTIGATIONS

**Following investigations are recommended to be undertaken / requested urgently. If unsure discuss with Senior**

- **Bloods:** FBC / U&E / LFT / Ca / PO<sub>4</sub> / Mg / Gluc / Coag / CRP
- **Blood cultures**
- **Urine MC&S**
- **Imaging:**
  - CXR
  - USS Abdo

- **Ascitic tap:**
  - All patients irrespective of clotting parameters
  - MC&S
  - Albumin
  - +/- Cytology (if cancer suspected)

## MANAGEMENT

**Complete BASL Decompensated Cirrhosis Care Bundle for all patients in first 24 hours**

**Following management options can be considered in each scenario. If unsure discuss with Senior**

### ALCOHOL

- If >8units/day Males or >6units/day Female:
- IV Pabrinex 2 pairs TDS
  - Evidence of withdrawal:
    - Benzodiazepine dosing
    - CIWA scoring

### SUSPECTED INFECTION

- Antibiotics as per trust protocol for source
- Ascitic neutrophils >250/ $\mu$ l = **SBP**:
  - IV Human Albumin Solution (HAS) 1.5g/kg
  - Further dose of 1g/kg on Day 3

### AKI

- Stop / hold all diuretics and nephrotoxic drugs
- Fluid resuscitate:
  - 5% HAS or 0.9% sodium chloride
  - 1-2l will correct most losses
- Start fluid balance charts + daily weights:
  - Aim MAP >80mmHg
  - Aim Urine output >0.5ml/kg/hr
- Monitor regularly - if not meeting above targets consider escalation of care

### UPPER GI BLEED

- **See UGIB Mx document**
- Fluid resuscitate:
  - Aim MAP >65mmHg
- If variceal bleed:
  - IV Terlipressin 2mg QDS
    - Caution if known IHD or PVD
  - Prophylactic antibiotics as per trust guidelines
  - Endoscopy after resuscitation:
    - Ideally within 12 hours
- If prolonged PT give IV vit K 10mg STAT
- If PT >20 seconds give FFP 2-4 units
- If Platelets <50/L give platelets
- If Hb <7.0g/L or massive bleeding:
  - Transfuse RBC

### ENCEPHALOPATHY

- Lactulose 20-30ml QDS or Phosphate enema
  - Aim 2 soft stools/day
- Consider CT head to exclude subdural

### VTE PROPHYLAXIS

- Patients with liver disease are **very high risk**
  - Even with a prolonged PT

- VTE prophylaxis as per trust protocol
- Withhold if:
  - Active bleeding / Platelets <50

**Always consult BNF for dose / administration and contraindications for all above medications**

**Always consult local guidelines / Trust protocol regarding any transfusion products**

## CONTACT SENIOR

- **Decompensated cirrhosis is a medical emergency with a high mortality**
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