

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 / PO₄ / 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

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/ μ 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

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