Patient details

Decompensated Cirrhosis Care Bundle - First 6 hours

ALL patients presenting with symptoms/signs of decompensated cirrhosis[1] →

- *Bloods:* FBC, LFT, U/Es, clotting, Ca^{2+}, PO_4, Mg, CRP, lactate, glucose ❑
- *Septic screen:* CXR ❑ Urine dipstick ❑ Blood cultures ❑
- *Clinical ascites:* Ascitic tap ESSENTIAL[2]; cell count, MCS, protein, albumin ❑
- Request USS abdomen including Doppler of hepatic and portal vein ❑
- VTE prophylaxis, unless platelets <50 or active bleeding ❑
- Referral to dietetics made ❑
- Specialist review: refer to GI/liver team at earliest opportunity ❑

Ongoing alcohol intake? *(If NO- move to next section)* →

- IV Pabrinex/Thiamine as per hospital guidelines ❑
- Commence CIWA or GMAWS according to hospital guidelines ❑
- Monitor for refeeding syndrome ❑

N/A ❑

Spontaneous Bacterial Peritonitis? *(If NO- move to next section)* →

- *(Diagnosis: Ascitic neutrophils >250/mm3 or >0.25 x 10^9/L)*
- Prescribe 1.5g/kg of 20% Human Albumin Solution (HAS) ❑
- Antibiotics as per hospital guidelines ❑

N/A ❑

Acute Kidney Injury as per KDIGO criteria[3] *(If NO- move to next section)* →

- Suspend all diuretics and nephrotoxic drugs ❑
- Fluid resuscitate with crystalloid in 250ml boluses ❑
- Strict urine output monitoring ❑

At 6 hours, if deteriorating despite this, obtain senior review and consider escalation to ITU/HDU.

N/A ❑

GI bleeding AND varices suspected? *(If NO- move to next section)* →

- Target Hb 7-8 g/L, but if massive bleeding aim for Hb >8g/L ❑
  It is not recommended to routinely correct INR/APTT with blood products (unless on anticoagulants).
- Terlipressin: if no clear contraindications[4] prescribe 2mg stat IV followed by 2mg QDS ❑ (*If contraindication to Terlipressin, contact on-call GI bleed team and consider dose reduction/alternate agent[4]*)
- Prescribe prophylactic antibiotics as per hospital guidelines ❑

N/A ❑

Symptoms/signs of Hepatic Encephalopathy? →

- Lactulose 20-30mls QDS or phosphate enema ❑
- If clinical concern, for CT head to rule out a subdural haematoma ❑

N/A ❑

Name ..... Grade ..... Date ..... Time ..... ([1,2,3,4]) Please turnover for additional information

([1,2,3,4]) Important additional information

[1] Presentation of Acute Decompensation of Cirrhosis

Jaundice
Ascites
Hepatic Encephalopathy
Suspected Variceal Haemorrhage

[2] Diagnostic Ascitic Tap

Performed with a green needle, IRRESPECTIVE of clotting parameters.

Ensure ascitic fluid goes into universal container bottles for fluid albumin, MCS (with WCC differential) and blood culture bottles (minimal 5mls each bottle) to maximise yield of diagnosis of SBP.
Human Albumin Solution (HAS): 20g of albumin in 100ml of 20%.

[3] Acute Kidney Injury as per: Kidney Disease Improving Global Outcomes criteria (KDIGO)

1. Increase in serum creatinine ≥ 26 µmol/L within 48 hours *or*
2. ≥50% rise in serum creatinine over the last 7 days *or*
3: Urine output (UO) <0.5mls/kg/hr for more than 6 hours based on dry weight *or*
4: Clinically dehydrated.

[4] Variceal Haemorrhage

Contraindications to Terlipressin:
Absolute- Hypersensitivity, pregnancy, acute respiratory distress/hypoxia, septic shock, Creatinine ≥ 442µmol/l.
Relative- Age >70, peripheral arterial disease, prolonged QTc, cardiac arrhythmia, uncontrolled hypertension, acute coronary syndrome, previous myocardial infarction.

Alternative to Terlipressin:
Octreotide: 50 micrograms bolus followed by 25-50micrograms/hr infusion.

Suspend B blockers if Terlipressin/Octreotide commenced.

Stable patients: Routine administration of platelets, FFP, PCC and other products to correct haemostatic tests is ***not*** recommended outside of patients taking anticoagulants.

Unstable patients: Discuss with the upper GI bleed team +/- Haematologist +/- and consider major haemorrhage protocol. Avoid FFP in portal hypertension. Critical care review.