

DECOMPENSATED CIRRHOSIS CARE BUNDLE - FIRST 6 HOURS

TARGET AUDIENCE	Secondary care
PATIENT GROUP	Adult patients presenting with symptoms/signs of decompensated cirrhosis

Clinical Guidelines Summary

Guidance for the management of patients with decompensated cirrhosis in the first 6 hours of their admission into secondary care.

This is a revised version of the national “Decompensated Cirrhosis Admission Care Bundle” from the British Society of Gastroenterology/ British Association for the Study of the Liver (BSG/BASL).

Glossary:

BSG, British Society of Gastroenterology,
 BASL, British Association for the Study of the Liver;
 APTT, activated partial prothrombin time;
 CRP, C reactive protein;
 CXR, chest X-ray;
 FBC, full blood count;
 FFP, fresh frozen plasma;
 GMAWS, Glasgow Modified Assessment and Management of Alcohol tool;
 LFT, liver function test;
 MCS, microscopy, culture and sensitivity;
 PCC, prothrombin complex concentrate;
 U/E, urea and electrolytes;
 VTE, venous thromboembolism.
 WBC, White Blood Cell.
 USS, Ultrasound scan.

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Decompensated Cirrhosis Care Bundle - First 6 hours

All patients presenting with symptoms/signs of decompensated cirrhosis¹

- Bloods:* FBC, LFT, U/Es, clotting, Ca²⁺, PO₄, Mg, CRP, lactate, glucose
- Septic screen:* CXR Urine dipstick Blood cultures
- If ascites present:* Ascitic tap **ESSENTIAL**²; cell count, MCS, protein, albumin
- Request USS abdomen including Doppler of hepatic and portal vein
- VTE prophylaxis, unless platelets <50 x 10⁹/L 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 Vitamins B+C High Potency/Thiamine as per hospital guidelines
- Commence GMAWS according to hospital guidelines
- Monitor for refeeding syndrome
- See NHS Lanarkshire Refeeding Syndrome guideline*

N/A

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

- (Diagnosis: Ascitic fluid WBC >500/mm³)*
- Assess fluid status
- Prescribe 1.5g/kg of 20% Human Albumin Solution (HAS)
- HAS: 20g of albumin in 100ml of 20%*
- Antibiotics as per hospital guidelines

N/A

Acute Kidney Injury as per KDIGO criteria³
(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 70-80 g/L, but if massive bleeding aim for Hb >80g/L
- It is not recommended to routinely correct INR/APTT with blood products (unless on anticoagulants).*
- Terlipressin: if no clear contraindications⁴ prescribe 2mg stat IV followed by 2mg FOUR times daily *(If contraindication to Terlipressin, contact on-call consultant and consider dose reduction/alternate agent⁴)*
- In all GI bleeds, prescribe prophylactic antibiotics as per hospital guidelines

N/A

Symptoms/signs of Hepatic Encephalopathy?

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

N/A

(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.

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

1. Increase in serum creatinine $\geq 26 \mu\text{mol/L}$ within 48 hours *or*
2. $\geq 50\%$ rise in serum creatinine over the last 7 days *or*
- 3: Urine output (UO) $< 0.5\text{mls/kg/hr}$ 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 $\geq 442\mu\text{mol/l}$.

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 on call consultant +/- Haematologist +/- and consider major haemorrhage protocol. Avoid FFP in portal hypertension. Critical care review.

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References/Evidence

- McPherson S, Abbas N, Allison MED, et al. Decompensated cirrhosis: an update of the BSG/BASL admission care bundle, Frontline Gastroenterology, Published Online First: 16 April 2025. doi: 10.1136/flgastro-2025-103074

Appendices

1. Governance information for Guidance document

Lead Author(s):	Sean Haughey
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CHANGE RECORD			
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