Decompensated Cirrhosis First 6 Hours Care Bundle

Guidance notes for completion

- *Bundle to be completed within 6 hours of admission/diagnosis*
- *Commence NEWS2 monitoring to allow early recognition of deterioration*
- *Seek Senior Support*
- *Escalate to Critical Care if appropriate*
- *Refer to Gastroenterology Consultant for review within 72hours (Gastroenterology consultant is available Mon-Fri 9-5pm, review within 24hours Mon-Fri)*

Warnings:

- *Must be commenced within 6 hours and completed within 24hours of admission. Please print this document and place in patient case notes.*

Apply Demographic Label

HCR no……
CHI no.....
First Name.....
Surname.....
Date of Birth .....

1 Essential Screening for Decompensated Cirrhosis *(all suspected patients)*

Investigations			
Bloods *(please tick)*	FBC ☐ LFTs ☐ U & E ☐ Ca^{2+} ☐ PO_4 ☐ Mg ☐ CRP ☐ Lactate ☐ Glucose ☐		
Sepsis Screen *(please tick)*	CXR ☐ Urinalysis ☐ Blood Cultures ☐	*Ascitic Tap (if clinically detectable ascites)*	Cell count ☐ MCS ☐ Protein ☐ Albumin ☐

- Refer patient to Dietitian via TrakCare
- Request USS abdomen (including doppler of hepatic and portal vein)
- VTE Prophylaxis (unless platelets <75 or signs of active bleeding)
- Refer patient to GI/Liver Team

2 Alcohol Screening / Management

- Ask patient if they continue to drink alcohol – if no, move to section 3

Alcohol Withdrawal Management for Active Alcohol Intake	
Prescribe	IV Vitamin B + C High Potency (2 pairs of vials three times daily) ☐
Commence	Ayrshire Assessment and Management of Alcohol Withdrawal Syndrome (AAMAWS) ☐

Warnings:

- *Patient at risk of refeeding syndrome – continue to re-assess*

3 Spontaneous Bacterial Peritonitis (SBP) Screening / Management

- Ascitic WCC> 500x 10^6 /L is diagnostic of Spontaneous Bacterial Peritonitis
- *If no signs of Spontaneous Bacterial Peritonitis, move to section 4*

Spontaneous Bacterial Peritonitis Management	
Prescribe	1.5g/kg of 20% Human Albumin Solution (HAS) at diagnosis of SBP ☐
	Antibiotics as per hospital guidelines ☐

4 Acute Kidney Injury – KDIGO Criteria

- *If no AKI, move to Section 5*

Acute Kidney Injury Management	
Fluid Resuscitation	Prescribe IV Hartmanns in 250ml boluses ☐
Medication Review	Discontinue prescribed diuretics and nephrotoxic medications ☐
Monitoring	Commence accurate fluid intake/output recording ☐
Procedures	Urinary catheterisation, if clinically indicated ☐

5 GI Bleeding and Varices Screening / Management

- *If no active GI bleeding and no varices suspected, move to section 6*
- Target Hb 70-80g/L

Alerts:

- *If signs of major haemorrhage aim for Hb > 80g/L*
- *It is not recommended to routinely correct INR/APTT with blood products (unless on anti-coagulants)*

GI Bleeding and Varices Management	
Prescribe	2mg IV Stat Terlipressin ☐ > followed by 2mg Terlipressin 6 hourly ☐ *If Terlipressin contraindicated refer to section 8 for contraindications > contact on-call GI bleed team and consider dose reduction/ alternate agent*
	Prophylactic Antibiotics as per NHSAA Guidelines ☐

- *Refer to NHSAA Upper GI Bleeding SOP/Bundle uhc-upper-gi-bleeding-bundle.pdf*

6 Hepatic Encephalopathy Screening and Management

Hepatic Encephalopathy Management	
Prescribe	Lactulose 20-30mls 6 hrly or phosphate enema ☐
Escalate	If clinical concern, CT Head to exclude subdural haematoma ☐

7 Record of Assessment

Record of Assessment				
Name		GMC Number		
Grade		Date/Time		

8 Key Additional Information

8.1.1 Presentation of Acute Decompensation of Cirrhosis

Jaundice; Ascites; Hepatic Encephalopathy; Suspected Variceal Haemorrhage

8.1.2 Acute Kidney Injury as per the Kidney Disease Improving Global Outcomes (KDIGO) criteria

1. Increase in serum creatinine ≥ 26µmol/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 or AKI
a) *For fluid balance chart ensure both fluid intake and output are documented*
b) *Urinary catheter is indicated in hepatorenal syndrome*

8.1.3 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:
Must be discussed with a gastroenterology consultant before initiation.

Suspend B blockers if Terlipressin 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

9 Acknowledgements

The British Society of Gastroenterology

The British Association for the study of the Liver

The Society for Acute Medicine