



Decompensated Cirrhosis Care Bundle - First 24 Hours

Decompensated cirrhosis is a medical emergency with a high mortality. Effective early interventions can save lives and reduce hospital stay. This checklist should be completed for all patients admitted with decompensated cirrhosis within the first 6 hours of admission.

a) NEWS FBC U/E U/E LFT Coag GIUC CAPOU/MG INTENDED STATES	1	L. Inv	vest	igatio	ons													
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AKI defined by modified RIFLE criteria 2: ≥50% rise in serum creatinine over the last 7 days or 3: Urine output (UO) <0.5mls/kg/hr for more than 6 hrs based on dry weight or 4: Clinically dehydrated Initials: a) Suspend all diuretics and nephrotoxic drugs Y N NA b) Fluid resuscitate with 5% Human Albumin Solution or 0.9% Sodium Chloride (250ml boluses with regular reassessment: 1-2L will correct most losses) Y N c) Initiate fluid balance chart/daily weights Y N d) Aim for MAP>80mmHg to achieve UO>0.5ml/kg/hr based on dry weight Y N e) At 6 hrs, if target not achieved or EWS worsening then consider escalation to higher level of care Y N NA b) Prescribe IV terlipressin 2mg four times daily (caution if known ischaemic heart disease or peripheral vascular disease; perform ECG in >65yrs) Y N NA b) Prescribe prophylactic antibiotics as per Trust protocol (cefuroxime unless contraindicated) Y N NA c) If prothrombin time (PT) prolonged give IV vitamin K 10mg stat Y N NA f) If platelets <50 – give IV platelets	2	1. Ac	ute	kidno	ey ir	njury	and/o	r hyp	onatra	emia (Na <1	L25 mmol	/L)			N//	Α 🗖	
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Continues overleaf.. \rightarrow

e	N/A 🗖						
a)	Look for precipitant (GI bleed, constipation, dehydration, sepsis etc.)	YN	Initials:				
b)	Encephalopathy – lactulose 20-30ml QDS or phosphate enema (aiming for 2 soft stools/day)	YN	Time:				
c)	in clinical doubt in a confused patient request CT head to exclude subdural YN ematoma		N/A				
7. Other							
a)	Venous thromboembolism prophylaxis – prescribe prophylactic LMWH (patient: liver disease are at a high risk of thromboembolism even with a prolonged prothrombin time; w if patient is actively bleeding or platelets <50)	Y N NA	Initials: Time:				
b)	GI/Liver review at earliest opportunity (ideally within 24 hrs)						

Name......Date......Time......

Decompensated Cirrhosis Care Bundle - First 24 Hours

The recent NCEPOD report 2013 on alcohol related liver disease highlighted that the management of some patients admitted with decompensated cirrhosis in the UK was suboptimal. Admission with decompensated cirrhosis is a common medical presentation and carries a high mortality (10-20% in hospital mortality). Early intervention with evidence-based treatments for patients with the complications of cirrhosis can save lives. This checklist aims to provide a guide to help ensure that the necessary early investigations are completed in a timely manner and appropriate treatments are given at the earliest opportunity.

- Decompensated cirrhosis is defined as a patient with cirrhosis who presents with an acute deterioration in liver function that can manifest with the following symptoms:
 - o Jaundice
 - Increasing ascites
 - Hepatic encephalopathy
 - Renal impairment
 - GI bleeding
 - Signs of sepsis/hypovolaemia
- Frequently there is a precipitant that leads to the decompensation of cirrhosis. Common causes are:
 - GI bleeding (variceal and non-variceal)
 - o Infection/sepsis (spontaneous bacterial peritonitis, urine, chest, cholangitis etc)
 - Alcoholic hepatitis
 - Acute portal vein thrombosis
 - Development of hepatocellular carcinoma
 - Drugs (Alcohol, opiates, NSAIDs etc)
 - Ischaemic liver injury (sepsis or hypotension)
 - Dehydration
 - Constipation

When assessing patients who present with decompensated cirrhosis please look for the precipitating causes and treat accordingly. The checklist shown overleaf gives a guide on the necessary investigations and early management of these patients admitted with decompensated cirrhosis and should be completed on all patients who present with this condition. The checklist is designed to optimize a patient's management in the first 24 hours when specialist liver/gastro input might not be available. Please arrange for a review of the patient by the gastro/liver team at the earliest opportunity. Escalation of care to higher level should be considered in patients not responding to treatment when reviewed after 6 hours, particularly in those with first presentation and those with good underlying performance status prior to the recent illness.