Hairmyres Hospital Decompensated Cirrhosis Care Bundle
The First 24 hours

Name _____ Grade _____ Date _____ Time _____

On Admission

- Bloods ☐
  Inc Coag
  $Ca/PO_4/Mg$
- CXR ☐
  Urine dip ☐
- Ascitic tap in all patients with ascites ☐
  regardless of coag
- Request
  abdo US ☐
- Consider LMWH for VTE prophylaxis ☐

Alcohol

- Record Daily intake ____
  if high follow below
- IV pabrinex
  2 pairs TID
  ☐
- Symptom triggered lorazepam as per GMAWS
  ☐
- Refer to substance misuse on 4626

Infections

- Sepsis?
  Y ☐ N ☐
- Suspected Source of Infection
  _____
- Sepsis 6 and IV Abx as per Lanarkshire guidelines ☐
- If ascitic WCC >500 or polymorphs >250 – treat as SBP
  IV co-amoxiclav ☐
  20% albumin 1.5g/kg day 1 ☐
  1g/kg day 3 ☐

AKI and/or hyponatraemia

- RIFLE AKI criteria
  Creatine ↑26 over 48hrs
  Creatinine 1.5x baseline over 7d
  UO <0.5mls/hr over 6 hrs
- Suspend all diuretics and nephrotoxics ☐
- Fluid resuscitate with 0.9% Saline ☐
- Fluid balance chart and aim for UO >0.5ml/kg and MAP >80 ☐

GI bleeding

- Fluid resuscitate and complete the AUGIB bundle ☐
- IV terlipressin 2mg QID (unless contraindicated) ☐
  IV co-amoxiclav ☐
- If INR >2.0 or platelets <50 then dw haematology and correct ☐
- Transfuse aiming for Hb 70-80 ☐
- Dw oncall surgical team re endoscopy ☐

Confusion/ Encephalopathy

- Consider Precipitants
  -GI bleeding
  -Constipation
  -Dehydration
  -Sepsis
- Lactulose 20-30ml QID or phosphate enemas ☐
  Aiming 2 soft motions per day
- Rifaxamin
  550mg BD ☐
- Consider subdural and CTB if appropriate ☐

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Additional Notes

Decompensated Cirrhosis is a medical emergency with high mortality (10-20%). Effective early intervention with evidence based treatments 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.

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:

- Jaundice
- Increasing or new ascites
- Hepatic encephalopathy
- Renal impairment
- GI bleeding
- Signs of sepsis or hypovolaemia

Frequently there is a precipitant that leads to the decompensation of cirrhosis. Common causes are:

- GI bleeding (variceal and non-variceal)
- Infection/sepsis (SBP, urine, chest, cholangitis etc)
- Alcoholic hepatitis
- Acute portal vein thrombosis
- Development of hepatocellular carcinoma
- Drugs (alcohol, opiates, paracetemol, nsaids etc)
- Ischaemic liver injury (sepsis or hypotension)
- Dehydration
- Constipation

Ascitic tap – All patients with ascites should have an ascitic tap carried out regardless of coag. This should be performed with a syringe and a green needle and can be done without US marking. Samples should be sent in a universal container a FBC bottle and in two blood culture bottles. Please request fluid albumin, cell count, fluid culture and gram stain and alert the on-call micro technician.

US Scan – Please request for all patients to look for causes of decompensation such as HCC or portal vein thrombosis

LMWH – Despite coag results most cirrhotic patients are pro-thrombotic due to imbalance of clotting factors, please consider LMWH in all patients with platelets above 50 and no bleeding.

Sepsis – Infection is a common trigger for decompensation but cirrhotic patients are often immunocompromised and do not mount the same response often having low CRP. Rapid diagnosis and treatment is vital.

AKI – Due to low muscle mass in cirrhosis many cirrhotic patients have very low baseline creatinine and it is important to assess change in creatinine using rifle criteria as often patients can have AKI with creatinine still in the normal range or only modestly increased.