Advanced Liver Disease
Care Guide
April 2019
GOALS

- Diagnose F3/F4 Cirrhosis early and screen for HCC*
- Diagnose and treat complications
- Delay decompensation
- Early identification of patients who are appropriate for Palliative Care/Hospice – Ensure POLST done

ALERTS

- Abdominal Pain: Consider Spontaneous Bacterial Peritonitis (SBP)
- Mental status changes – consider encephalopathy
- Hematemesis/Melena
- Fever- Consider SBP
- Oliguria/Anuria
- Rapid weight gain or loss – fluid gain/loss

DIAGNOSTIC CRITERIA FOR CIRRHOSIS AND DECOMPENSATED CIRRHOSIS

Cirrhosis is best predicted by these findings¹:

- Ascites (likelihood ratio for cirrhosis [LR] 7.2)
- Platelet count < 160,000/mm³ (LR 6.3) **severe thrombocytopenia often precedes other manifestations
- Spider angiomata on physical exam (LR 4.3)

Cirrhosis (liver fibrosis stage 4) is diagnosed with one or more of the following:

- Imaging: hepatic ultrasound, CT, MRI
- Calculations: FIB4 online calculator
- Procedure: liver biopsy, transient elastography (FibroScan™)
- Physical exam

Decompensated Cirrhosis is defined by the presence of:

- Ascites
- Hepatic encephalopathy (HE)
- *Hepatocellular carcinoma (HCC)
- Hepatorenal syndrome
- Hepatopulmonary syndrome
- Child-Pugh class B and C (See page 5)
- SBP
- Variceal bleeding

EVALUATION

Complete clinical history and physical exam

- History: Especially risk factors for hepatitis; symptoms of significant liver disease: hematochezia, melena, hematemesis, weight gain, abdominal distension
- Physical Exam: Particularly mental status changes, skin changes, hepatosplenomegaly, spider angiomata, weight changes, hematemesis, jaundice and edema in addition to usual review of symptoms components
- Pay attention to the presence of complications of liver disease (i.e., ascites, esophageal varices, hepatic encephalopathy, SBP) indicative of decompensated cirrhosis

Medication List Review

- Avoid hepatotoxins and chronic NSAID use
- Multiple drugs have altered kinetics in patients with severe liver disease; dose alterations frequently required

Lab/Diagnostics

- CBC, CMP, PT/INR, hepatitis serologies, HIV testing
- Cirrhosis/F4: EGD (baseline) to screen for esophageal varices: follow-up based on clinical findings
- F3 and F4 fibrosis: US to screen for HCC every 6 months (AFP not recommended as the only tool to screen for HCC)

**TREATMENT**

Vaccinations: influenza annually, pneumococcal vaccines, if not immune, consider vaccinating for: HAV, HBV

Medications or other therapies based on specific patient findings (See below and pages 6-11)
- Ascites: optimize volume management (diuretics and salt restriction); consider midodrine for refractory ascites
- Esophageal varices: determine if nonselective beta-blocker is indicated; order baseline EGD with follow-up as needed
- Hepatocellular carcinoma diagnosed: obtain consultation
- Hepatic encephalopathy: optimize lactulose and minimize potential for exacerbation
- Hepatitis C: consider treatment if no HCC and prognosis > 1 year – See CCHCS Hepatitis C Care Guide
- Liver transplantation: consult with CME or Regional DME for potential transplant candidates
- SBP: antibiotic therapy and prophylaxis

**MONITORING**

Follow-up visit
- Chronic Care visit as clinically indicated, typically at least every 180 days, but more frequently if unstable or decompensated cirrhosis
- Monitor changes in: mental status, weight, vital signs, skin

Labs
- Consider CBC, CMP, PT/INR annually or more frequently as indicated (especially if the patient has ascites and is on diuretics)

Ultrasound
- Every 6 months (HCC screening) for F3 and F4 fibrosis

EGD
- EGD (F4 only) at baseline, then as recommended by Gastroenterologist (GI), generally within 2-3 years (see page 9 for more details)