Advanced Liver Disease Care Guide

July 2020

Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient.

SUMMARY

GOALS

- ✓ Diagnose 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 (SPB)
- Mental status changes- consider encephalopathy
- Hematemesis/Melena
- Fever – Consider SBP
- Oliguria/Anuria
- Rapid weight gain or loss – fluid gain/loss

EVALUATION

Complete clinical history and physical exam

- History: especially risk factors for hepatitis and symptoms of significant liver disease (hematochezia, melena, abdominal distention, hematemesis, weight gain)
- 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: Esophagogastroduodenoscopy (EGD) (baseline) to screen for esophageal varices, follow-up based on clinical findings
- 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)

- 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, and 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 cirrhosis
- EGD: EGD (F4 only) at baseline, then as recommended by Gastroenterologist (GI), generally within 2-3 years