

Decompensated Cirrhosis Care Bundle – First 24 Hours

Complete this checklist within the first 6 hours of hospitalisation as a framework for care in the first 24 hours of admission

Decompensated cirrhosis is defined by the development of overt clinical signs of chronic liver disease.

Signs of Decompensated Cirrhosis
Ascites
Variceal Bleeding
Hepatic Encephalopathy
Non-obstructive jaundice

Common Precipitants of Decompensation
Infection/sepsis
- Spontaneous bacterial peritonitis
- Urinary tract infection
- Respiratory infection
- Cholangitis
Gastrointestinal bleeding
- Variceal or non-variceal
Intoxication or drugs
- Alcohol, opioids, benzodiazepines
New/progressive hepatocellular carcinoma
Acute portal vein thrombosis
Dehydration
Constipation (for encephalopathy)

Decompensated cirrhosis carries a **high mortality**. Sepsis and acute kidney injury are common. **Early intervention is vital.**

This checklist can be modified to add links to local protocols as needed and can also be completed electronically.

Presentation	
1.	<input type="checkbox"/> Observation Chart <input type="checkbox"/> FBC <input type="checkbox"/> EUC <input type="checkbox"/> LFTs <input type="checkbox"/> CRP <input type="checkbox"/> CMP <input type="checkbox"/> INR, APTT, Fibrinogen <input type="checkbox"/> Urine dipstick/MSU <input type="checkbox"/> Chest x-ray Liver ultrasound: <input type="checkbox"/> Requested <input type="checkbox"/> Done <input type="checkbox"/> Blood cultures
2.	Perform diagnostic paracentesis in all patients with ascites (irrespective of INR or platelets) <i>Use a 21G needle and 20ml syringe. Send for cell count, culture and fluid albumin</i>
3.	Record recent daily alcohol intake (1 standard drink = 10g ethanol)g/day
Alcohol - If the patient has a history of current excess alcohol consumption ie. >40g/day	
1.	Give IV thiamine 300mg daily <input type="checkbox"/> Done <input type="checkbox"/> N/A
2.	Start Alcohol Withdrawal Scale as per local protocol unless encephalopathic <input type="checkbox"/> Done <input type="checkbox"/> N/A
Infection - If sepsis or infection suspected	
1.	What is the suspected source?
2.	Treat with antibiotics specific to source as per local protocol <input type="checkbox"/> Done <input type="checkbox"/> N/A
3.	If ascitic fluid polymorph/neutrophil count >250x10 ⁶ /L, treat for spontaneous bacterial peritonitis: a. IV ceftriaxone 2g daily <input type="checkbox"/> Done <input type="checkbox"/> N/A b. Commence IV albumin 20% 1.5g/kg daily within 6 hours of diagnosis <input type="checkbox"/> Done <input type="checkbox"/> N/A
Acute Kidney Injury (AKI) and/or Hyponatraemia ie. Na <125 mmol/L	
AKI definition ICA modified KDIGO criteria	- Increase in serum creatinine > 26.5umol/L within 48 hours OR - >50% rise in serum creatinine from baseline over the last 7 days OR - Urine output (UO) <0.5ml/kg/hr for >6 hours (based on dry weight)
1.	Suspend all diuretics, nephrotoxic drugs, vasoactive drugs and beta-blockers if MAP <65 mmHg (or systolic BP < 90mmHg) <input type="checkbox"/> Done <input type="checkbox"/> N/A
2.	Intravenous volume expansion with 4% albumin or normal saline - If creatinine >133 umol/L (ie. > AKI Stage 1A), use 20% albumin 1mg/kg daily for 2 days <input type="checkbox"/> Done <input type="checkbox"/> N/A
3.	Initiate fluid balance chart/daily weighs, consider in-dwelling catheter <input type="checkbox"/> Done <input type="checkbox"/> N/A
4.	Aim for MAP>80mmHg to achieve urine output >0.5ml/kg/hr (based on dry weight) <input type="checkbox"/> Done <input type="checkbox"/> N/A
5.	At 6 hours, if target not achieved consider escalation to higher level of care <input type="checkbox"/> Done <input type="checkbox"/> N/A
Acute Gastrointestinal Bleeding - If the patient has evidence of GI bleeding and varices are suspected	
1.	Fluid resuscitation according to BP (aim MAP >65mmHg) and heart rate <input type="checkbox"/> Done <input type="checkbox"/> N/A
2.	IV terlipressin 1.7mg 4 hourly until bleeding controlled then reduce - consider octreotide if terlipressin contraindicated (eg. unstable angina, recent myocardial infarction, peripheral vascular disease) <input type="checkbox"/> Done <input type="checkbox"/> N/A
3.	IV ceftriaxone 1g daily for 3-5 days <input type="checkbox"/> Done <input type="checkbox"/> N/A
4.	Transfuse if Hb <70g/L, aim Hb 70-90g/L <input type="checkbox"/> Done <input type="checkbox"/> N/A
5.	Activate massive transfusion protocol if local criteria met - Avoid using fresh frozen plasma outside of massive transfusion protocols <input type="checkbox"/> Done <input type="checkbox"/> N/A
6.	Refer for endoscopy within 12 hours after resuscitation <input type="checkbox"/> Done <input type="checkbox"/> N/A
Hepatic Encephalopathy	
1.	Look for and manage precipitant (see list of common precipitants above) <input type="checkbox"/> Done <input type="checkbox"/> N/A
2.	Lactulose 30ml QID orally - If unable to take orally: nasogastric /rectal lactulose or phosphate enema <input type="checkbox"/> Done <input type="checkbox"/> N/A
3.	Consider CT head to exclude other causes of confusion or obtundation <input type="checkbox"/> Done <input type="checkbox"/> N/A
Other	
1.	Venous thromboembolism prophylaxis – do not withhold unless clinically significant bleeding – subcutaneous low molecular-weight heparin as per local protocol <input type="checkbox"/> Done <input type="checkbox"/> N/A
2.	Refer for Gastroenterology/Liver review <input type="checkbox"/> Done <input type="checkbox"/> N/A

Checklist completed by:

Designation:

Date:

Time: