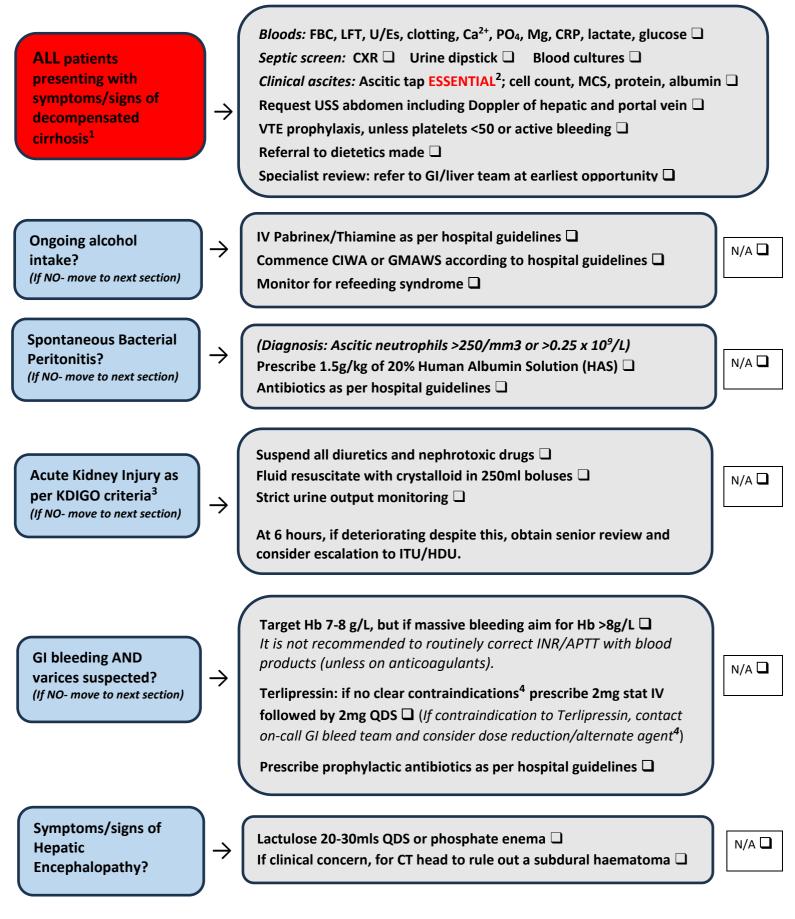




Decompensated Cirrhosis Care Bundle - First 6 hours



(^{1,2,3,4}) <u>Important additional information</u>

⁽¹⁾ Presentation of Acute Decompensation of Cirrhosis

Jaundice Ascites Hepatic Encephalopathy Suspected Variceal Haemorrhage

⁽²⁾ Diagnostic Ascitic Tap

Performed with a green needle, IRRESPECTIVE of clotting parameters.

Ensure ascitic fluid goes into universal container bottles for fluid albumin, MCS (with WCC differential) and blood culture bottles (minimal 5mls each bottle) to maximise yield of diagnosis of SBP.

Human Albumin Solution (HAS): 20g of albumin in 100ml of 20%.

⁽³⁾ Acute Kidney Injury as per: Kidney Disease Improving Global Outcomes criteria (KDIGO)

- 1. Increase in serum creatinine \geq 26 µmol/L within 48 hours *or*
- 2. ≥50% rise in serum creatinine over the last 7 days or
- 3: Urine output (UO) <0.5mls/kg/hr for more than 6 hours based on dry weight or
- 4: Clinically dehydrated.

⁽⁴⁾ Variceal Haemorrhage

Contraindications to Terlipressin:

Absolute- Hypersensitivity, pregnancy, acute respiratory distress/hypoxia, septic shock, Creatinine \geq 442µmol/l. **Relative**- Age >70, peripheral arterial disease, prolonged QTc, cardiac arrhythmia, uncontrolled hypertension, acute coronary syndrome, previous myocardial infarction.

Alternative to Terlipressin:

Octreotide: 50 micrograms bolus followed by 25-50micrograms/hr infusion.

Suspend B blockers if Terlipressin/Octreotide commenced.

Stable patients: Routine administration of platelets, FFP, PCC and other products to correct haemostatic tests is *not* recommended outside of patients taking anticoagulants.

Unstable patients: Discuss with the upper GI bleed team +/- Haematologist +/- and consider major haemorrhage protocol. Avoid FFP in portal hypertension. Critical care review.