Management of Alc Hep

CLINICAL SYNDROME

- Patient with heavy **alcohol intake** *(> 60 g/day or 2.5 oz/day for >3 months)*. Some patients stop drinking the last days/ weeks. Underreporting suspected if stigmata of alcoholism, compatible labs, positive alcohol screening, other organs affected (polyneuropathy, sarcopenia, pancreatitis).
- **Clinical presentation**: recent-onset jaundice, malaise, ascites, edema, itching, fever, SOB due to massive ascites, confusion/lethargy/agitation in some cases (DDx: HE, withdrawal sdr., alcohol brain damage, seizures).
- **Common physical exam findings**: signs of alcohol abuse (facial erythema, rhinophyma, Dupuytren, muscle wasting), stigmata cirrhosis, ascites, tender hepatomegaly, splenomegaly, pedal edema, asterixis, poor mental status, signs of cerebellar dysfunction, signs of peripheral neuropathy.
- **LABS**: abrupt rise in TBil >3 mg/dl (usually > 5 mg/dl), GOT>GPT (usually >2, unusual > 500 U/L), GGT >100 U/mL, Alk Phos normal or slightly elevated, Albumin <3.0 g/L, INR >1.5, Platelet count <150,000, elevated MCV.

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GENERAL MEASURES

- **Assessment**: mental status, presence signs HE or alcohol withdrawal, ascites (diagnostic tap in all cases; FFP if INR>2.5), presence of infections (pneumonia, cellulitis, SBP, UTI, meningitis). EKG, pan-culture, chest X-Ray, urinary sediment in all patients, presence of SIRS (2 elevated out of: T, HR, RR and leukocyte count), urinary output.
- Prevent/treat **OH withdrawal**: *moderate*, Baclofen in USA or Clometiazol in Europe; *severe*, benzodiazepines (caution: they can precipitate HE and favor further addiction); *if intubation needed*, Propofol.
- Vit K weekly, Vit B (1, 6 and 12) and folic acid supplementation.
- Ensure adequate **caloric and fluid intake**; daily protein intake of 1.5 g/kg bw. Consider NGT if malnutrition and preserved mental status and peristalsis. TPN only indicated in severe cases.
- If fever >38°C or clinical/microbiological signs of **infection**: BSA according to the local guidelines. If SIRS without infection and T<38°C: BSA not clearly indicated but high risk of renal failure and MOD.
- If ascites or GI hemorrhage: **primary prophylaxis** with norfloxacin and or ceftriaxone as indicated.
- Early detection of **AKI** (use AKIN criteria): expansion with albumin, consider terlipressin or NE if progressive HRS-1.
- Motivational intervention by **addiction** counselor while hospitalized. Referral to a local addiction counselor. Consider Baclofen as anticraving when liver function improves (TBil <10 mg/dL). Early follow-up visit in Liver Clinic.

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SCREENING CAUSES OF JAUNDICE

- Rule out biliary obstruction, metastases or HCC (doppler abdominal US and if indicated, MRI).
- Rule out drug-induced liver injury (DILI): http://livertox.nih.gov
- Rule our acute viral hepatitis (A, B and C) if first episode and/or clinical suspicion.
- Rule out severe autoimmune hepatitis if first episode and/or clinical suspicion (ANA, ASMA, IgG).

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DO WE NEED TO DO A TJB FOR DIAGNOSIS ?

- Hypotension/massive bleeding at admission.
- Sepsis at admission (clinical diagnosis or positive culture plus SIRS).
- Suspicion of malignant liver disease based on clinical and/or imaging criteria.
- Atypical labs (*eg*. GOT or GPT >500 U/L, Alk Phos >300 U/L, etc).
- Uncertain alcohol assessment.
- Cocaine use last 3 months.
- Use of any potential hepatotoxic substance in the last 3 months.

All negative → **TJB recommended**

Any positive → **TJB required**

TJB recommended → Not possible → **Clinically diagnosed Alc Hep**

TJB recommended ⇢ TJB required

TJB required → **Biopsy-proven Alc Hep**

TJB required → Not full criteria Alc Hep / Other diagnosis → Supportive therapy / Specific therapy of the finding

Maddrey DF >32
or
ABIC >9

Pentoxifylline (PTX) (400mg TID for 4 weeks) or Prednisolone 40 mg

Lille Model | ***7 days***

<0.45 → 4 weeks corticoids followed by a 2 week taper

≥0.45 →
- Stop Prednisolone.
- Consider OLT if approved in the center..

PREDNISOLONE or PENTOXIFYLLINE ?

- No consensus on contraindications.
- PTX prevents AKI (better in patients with SIRS or moderate AKI ?).
- Prednisolone avoided or delayed if sepsis at admission.
- PTX avoided if platelets <30,000.