REPATRIATION: CIRRHOTIC PATIENTS

Calgary Zone webinar series: Mental health & hot topics

Repatriation of stable cirrhotic patients from hepatology to the medical home

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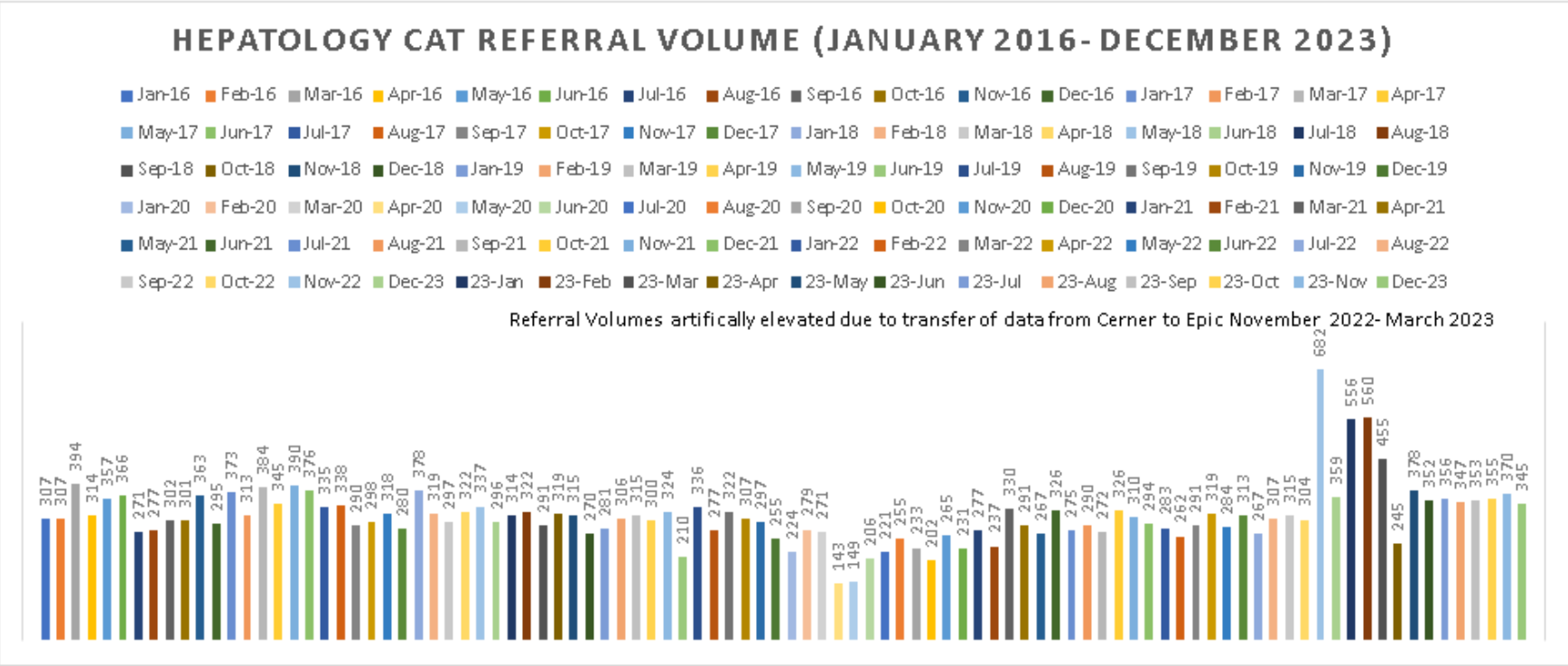
HEPATOLOGY CAT REFERRAL VOLUME (ALL REASONS)



19-Feb	19-Mar	19-Apr	19-May	19-Jun	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec
306	315	300	324	210	336	277	322	307	297	255
20-Feb	20-Mar	20-Apr	20-May	20-Jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec
279	271	143	149	206	221	255	233	202	265	231
21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec
237	330	291	267	326	275	290	272	326	310	294
22-Feb	22-Mar	22-Apr	22-May	22-Jun	22-Jul	22-Aug	22-Sep	22-Oct	22-Nov	22-Dec
262	291	319	284	313	267	307	315	303	682	360
23-Feb	23-Mar	23-Apr	23-May	23-Jun	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov	Dec-23
560	455	245	378	352	356	347	353	355	370	345

YEAR TOTAL
2019
3530
2020
2679
2021
3495
2022
3986
2023
4672

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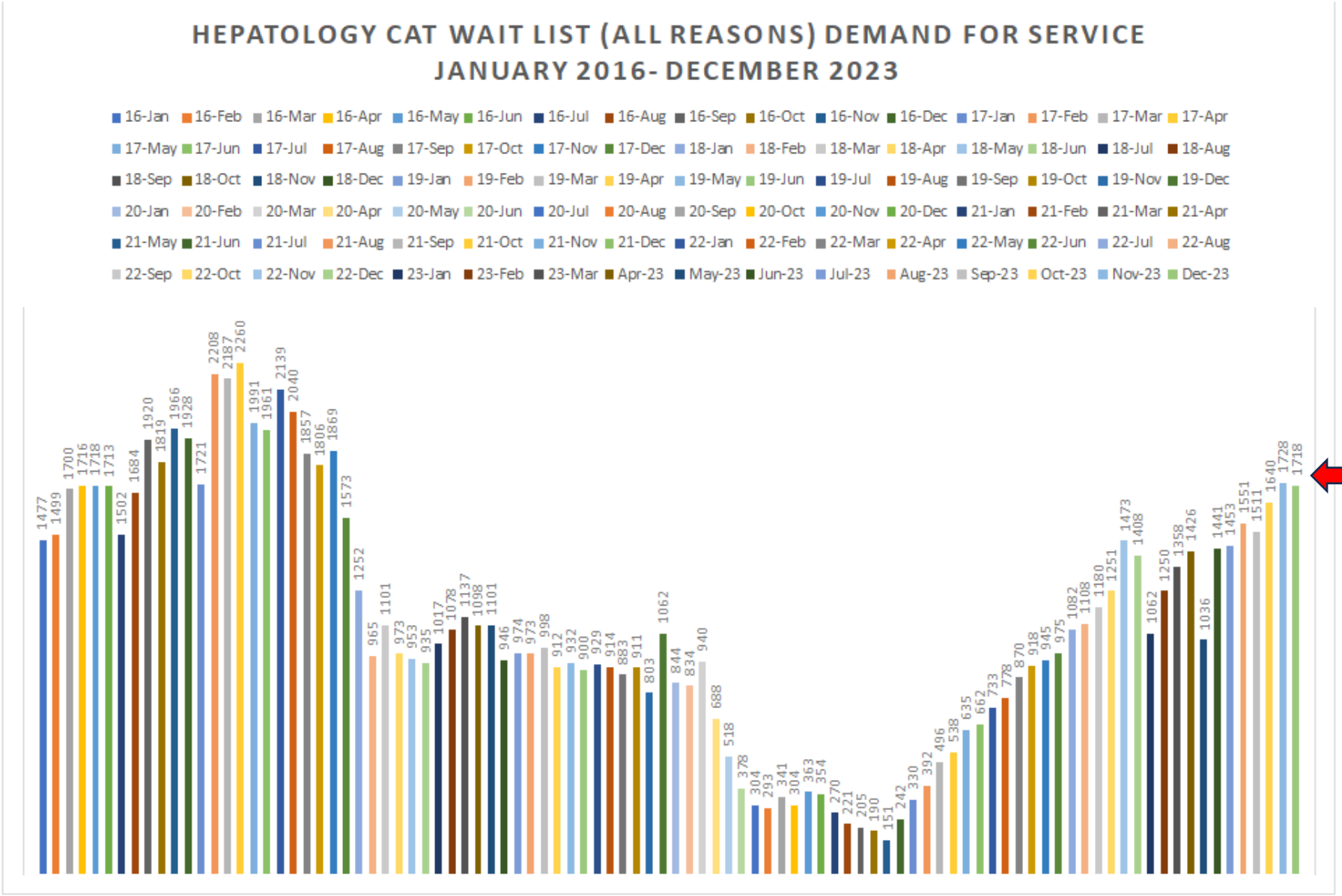
HEPATOLOGY CAT WAIT LISTS



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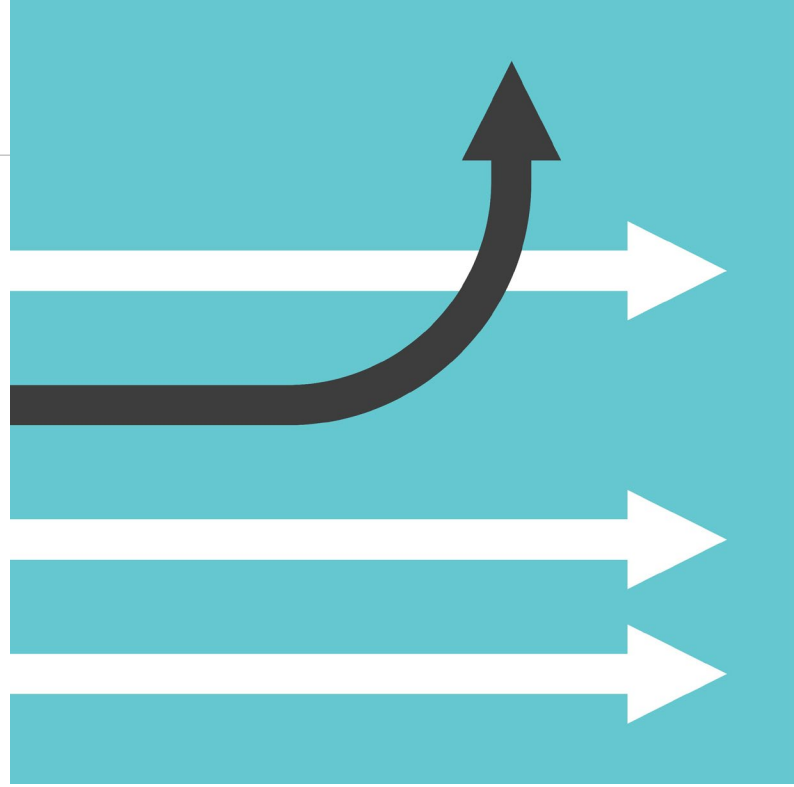

Who?

- Stable cirrhotics including:
  - Alcohol-related cirrhosis and continued abstinence
  - Cured hepatitis C

How?

- Repatriation letter to primary care from hepatology with clear directions for:
  - Ongoing care
  - Re-referral, if needed

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A) Clinically significant portal hypertension (csPHT):

- csPHT (has been/ has NOT been) diagnosed in your patient.
- Primary prevention of variceal bleeding and/or decompensation event with Carvedilol 6.25 mg bid for life (if SBP > 100 and no contraindications to beta blockade). Treatment has been started by hepatology, and they do not require repeat endoscopy *as long as they remain on carvedilol*.
- If contraindications existed for beta blockade or patient was intolerant, gastroenterology has already scheduled q 2-3 year follow up EGD. **You do not need to arrange.**
- If patient becomes intolerant to β blocker/ develops a contraindication, refer back to hepatology with reason for referral listed as “no longer able to use carvedilol – assess for EGD.”

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B) Routine monitoring for biochemical decompensation with q12 monthly bloodwork:

- Bili (T&D), INR, albumin (measures of liver function) and *refer back to specialist if bilirubin increases > ULN, or INR becomes >1.2, or if albumin decreases to < 35.*
- In addition, CBC (no diff), AST, ALT, Cr, sodium to allow for calculation of MELD score in case of decompensation or suspicion of clinical worsening.
- For other concerns use specialist advice telephone line (Specialist Link).
- If concern for recurrent alcohol consumption, then consider increased frequency of laboratory testing and referral to AUD pathway for guidance.

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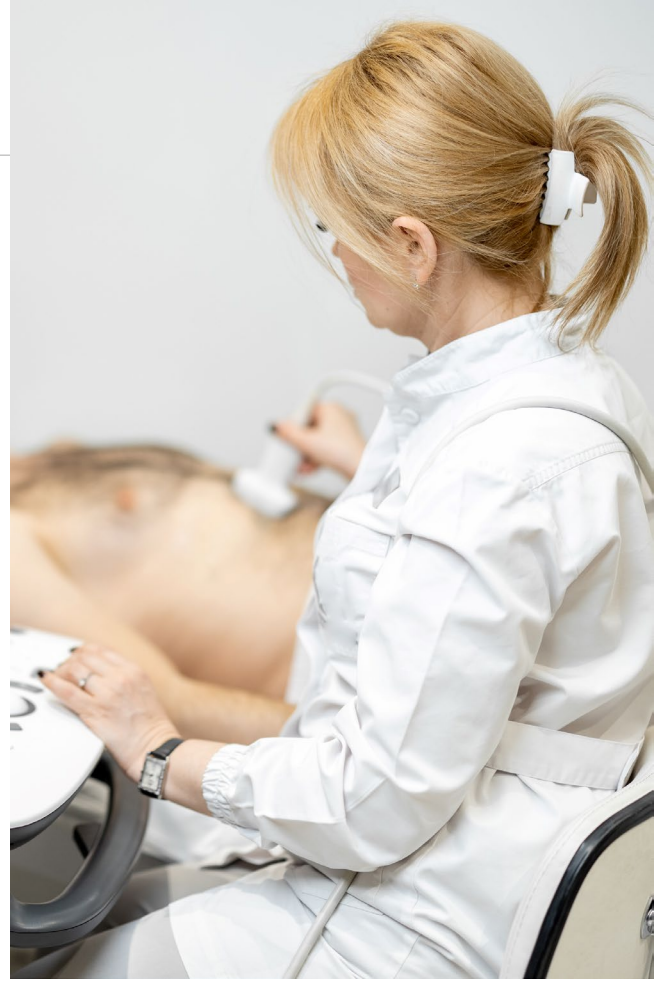
C) Hepatocellular cancer (HCC) screening with an abdominal ultrasound

- Performed by community radiology provider every 6 months until the patient is unlikely to benefit from interventions to treat any liver cancer found due to comorbidities (e.g.,: life expectancy < 1 year from other health issues or inability or unwilling to tolerate invasive procedure for HCC). Cirrhotic patients have a 2-3% chance per year of developing a HCC so screening for HCC is warranted.
- Patient has already been enrolled in a surveillance program at time of discharge. **You do not need to arrange these exams.**
    - *Refer back to specialist if diagnostic imaging reports LiRADS 4 or 5 lesion concerning for HCC or radiology recommends surveillance with another modality.*



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D) General advice that may impact other aspects of their care:

I. Avoid alcohol, oral NSAIDS, and use narcotics with extreme caution due to high sensitivity to sedating effects of narcotics in cirrhosis.
II. Atatins OK (rosuvastatin is the statin of choice in cirrhosis due to limited liver metabolism so doses up to 40 mg/day can be used in compensated cirrhosis. If a patient is already on atorvastatin, then the dose must be adjusted for cirrhosis to no more than 40 mg/day. Other statins have been poorly studied in cirrhosis.
III. Acetaminophen analgesic of choice in liver disease (up to 2 gms total/day).
IV. Vaccinations -- appropriate as per guidelines.
V. Osteoporosis prevention as per guidelines (cirrhotic patients are at increased risk for osteoporosis).
VI. Healthy, balanced diet with protein intake 1.5 g/kg/d and evening snack (details can be found at **https://cirrhosiscare.ca/**).
VII. No added salt diet.
VIII. Consider discontinuing PPI if possible (infection risk increased with PPIs).

FIB-4: LIVER HEALTH

Questions & comments