Advanced Research in Gastroenterology & Hepatology
ISSN: 2472-6400

Juniper Publishers
key to the Researchers

Mini Review
Volume 4 Issue 3 – March 2017
DOI: 10.19080/ARGH.2017.04.555637

Adv Res Gastroentero Hepatol

The Decompensated Cirrhosis Care Bundle for Acute Admissions: Implementation and Impact

Cargill Z, Tang K and Alisa A*

Department of Gastroenterology, Barnet Hospital, UK

Submission: March 03, 2017; **Published:** March 27, 2017

***Corresponding author:** Alisa A, Department of Gastroenterology, Barnet Hospital, Royal Free NHS Foundation Trust, UK, Email: akeelalisa@yahoo.com

Introduction

Acute Decompensated Cirrhosis (ADC) is a medical emergency that carries high mortality (10-20%). The British Society of Gastroenterology/British Association for the Study of the Liver has published an evidenced based Decompensated Cirrhosis Care Bundle (DCCB) checklist to be completed during the initial six hours of admission for all patients with ADC and for expert care to be implemented within 24 hours.

Methods

Patients were identified by the gastroenterology team inpatient referral system, admission notes and electronic records. It included 22 consecutive admissions with cirrhosis between18th April 2016 and 18th June 2016. This was following introduction of a modified liver care bundle into the trust. The aim was to compare our performance and outcomes after the introduction of the preformed to data collected prior to implementation.

Results

Twenty-two admissions with ADC were identified over the two-month period in April to June 2016. Performance prior to and post DCCB introduction can be seen in table 1. There was a substantial improvement in the numbers of imaging requested and early ascitic taps. Additionally, post DCCB implementation, a greater number of admissions with acute kidney injury or hyponatremia had fluid resuscitation with the recommended fluid regimen. However, the management of those with a suspected upper gastrointestinal bleed differed little. Inpatient mortality during data collection was 0% compared to 18% pre DCCB introduction which? Related to excess winter mortality/sicker patients at the time/?? (Table 1)

Table 1

	Pre DCCB Dec 2016- Feb 2016	**DCCB Implementation Apr 2016 – Jun 2016**
	Demographics	
N	40	22
Average length of stay	¯x 10 days [range 3-42 days]	13 days(range 2-57)
Sex Male	20(50%)	11(50%)
Sex Female	20(50%)	11(50%)
Age	¯x = 57 years(range 33 – 86 years)	¯x = 56 years(range 37 – 76 years)
Aetiology of Cirrhosis		
N	40	22
Alcoholic Liver Disease	29(73%)	17(77%)
NASH	3(8%)	3(14%)
Cryptogenic	4(10%)	0(0%)
HCV	2(5%)	0(0%)
Hemochromatosis	1(3%)	0(0%)

HBV	0(0%)	1(5%)
Unknown	1(3%)	2(10%)
Early Investigations		
N	40	22
New Early Warning Scores	40(100%)	22(100%)
FBC, U&E, CRP	40(100%)	22(100%)
Bone profile and Magnesium	25(63%)	14(64%)
Coagulation profile	37(85%)	22(100%)
Ascitic tap if clinical ascites present	11/29(38%)	9(75%)
Ultrasound Abdomen/Imaging	24(60%)	18(82%)
Recent Excessive Alcohol Consumption		
N	25	9
IV Pabrinex	25(100%)	9(100%)
CIWA score +alcohol reducing regimen	24(96%)	9(100%)
Suspected Infection		
N	19	8
Started on Antibiotics	19(100%)	8(100%)
Blood cultures	7(37%)	3(38%)
Acute Kidney Injury and/or Hyponatraemia		
N	19	6
Fluid resuscitation with sodium chloride	18(86%)	6(100%)
Fluid balance chart	20(95%)	6(100%)
Weight chart	4(19%)	1(17%)
Suspected GI Bleeding		
N	14	5
Endoscopy within 24 hours	13(93%)	4(80%)
Terlipressin administration	10(71%)	3(60%)
Antibiotics	11(79%)	1(20%)
Red Blood Cells transfusion	11(79%)	4(80%)
FFP transfusion	3(21%)	0(0%)
Encephalopathy		
N	40	22
Signs of encephalopathy	23(58%)	5(23%)
Gastroenterology Review		
N	40	22
Within 24 hours	33(83%)	21(95%)

Discussion and Conclusion

Introduction and implementation of the Decompensated Care Bundle is at its early stages. Already we have seen improvements in prompt management of ascites and timely arrangement of imaging. We would expect progress to continue as staff become more familiarised with the DCCB. To ensure effective use across our trust, accessibility and further education of staff should be addressed. Ongoing audit and assessment will help assess patient outcomes.

How to cite this article: Cargill Z, Tang K, Alisa A. The Decompensated Cirrhosis Care Bundle for Acute Admissions: Implementation and Impact. Adv Res Gastroentero Hepatol 2017; 4(3): 555637. DOI: 10.19080/ARGH.2017.04.555637

DOI: 10.19080/ARGH.2017.04.555637

How to cite this article: Cargill Z, Tang K, Alisa A. The Decompensated Cirrhosis Care Bundle for Acute Admissions: Implementation and Impact. Adv Res Gastroentero Hepatol 2017; 4(3): 555637. DOI: 10.19080/ARGH.2017.04.555637