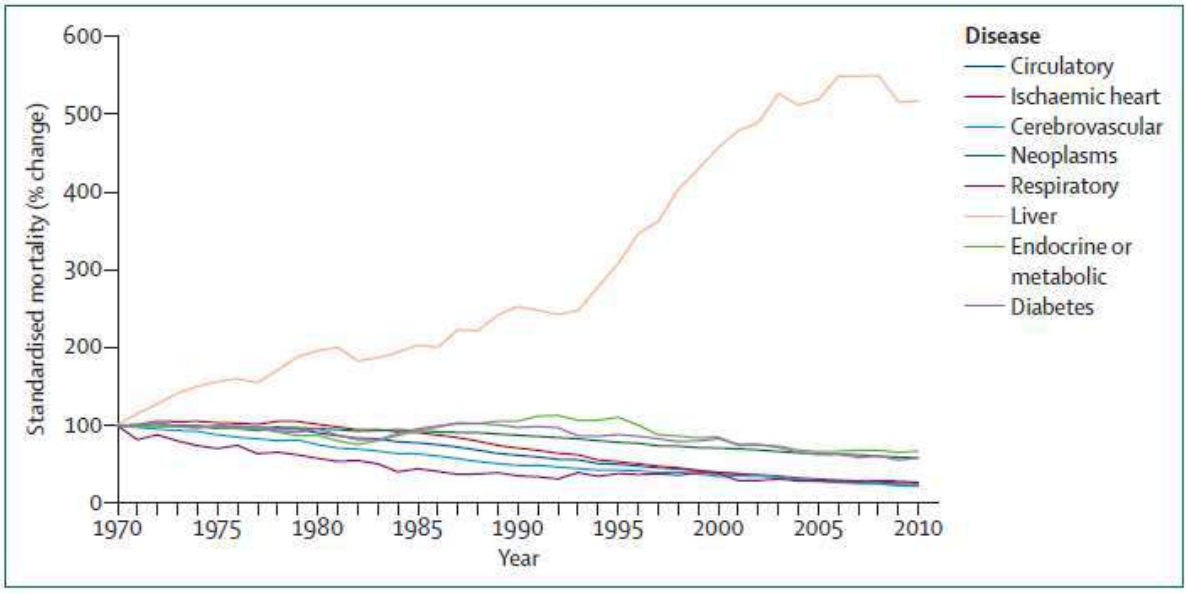
Blog of the Month

This month we have two Internal Medicine Trainees in the North East London region, Dr Rebecca Newell and Dr Eilis Kempley giving us an introduction into Chronic Liver Disease and Palliative Care. Any comments or questions, or want to submit your own blog post? Then get in contact at apmj.submissions@gmail.com. Thank you Dr Newell and Dr Kempley!

Chronic liver disease and palliative care

Chronic liver disease is an increasing cause of morbidity and mortality in the UK (figure 1) (1). Cirrhosis is the final common pathway for a number of aetiologies of chronic liver disease, including alcoholic liver disease, viral hepatitis, non-alcoholic fatty liver disease and autoimmune causes to name a few. For patients with decompensated cirrhosis, the mortality is high with a median survival of just two years (2). This blog will focus on palliative care in this complex cohort of patients, thinking about our experiences as junior doctors and some tips on the common symptoms in cirrhosis.



The symptom burden for cirrhosis is large, and whilst this group of patients often have a lot of contact with health care providers, with multiple admissions for acute treatment and disease surveillance, addressing their symptoms and advanced care planning can often be overlooked.

We have a few ideas as to why this happens. The concepts of palliative care and advanced care planning have historically been focused on oncology patients, the actively dying or the elderly. In contrast, patients with chronic liver disease are often young with an unpredictable disease course;

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each acute decompensation is potentially reversible if the trigger is identified and treated, and if not, the option of liver transplant is often under consideration. However, by focusing on each acute admission we can overlook the overall poor prognosis and disease progression, missing valuable opportunities for palliative care interventions.(3)

In addition, alcohol-related liver disease accounts for 60% of all cirrhosis in the UK. Those with ongoing alcohol or substance misuse issues can be challenging to care for in a hospital setting and the community. A high proportion of patients feel stigmatised for their illness, which can lead to distrust of medical practitioners and disengagement with services (4). Rules over drug and alcohol consumption on site may deter patients from a hospice admission or nursing home placement. As a result, they may remain in accommodation where their symptoms are not well controlled.

As junior members of the medical team, we tend to spend the most time at the bedside, interacting with patients and their relatives. This exposure makes us aware of how patients often feel trapped in a revolving door of admissions, with varying degrees of awareness at how close they are to the end of their life. It also means we may be more attuned to their individual concerns; for instance, a young woman with ascites may divulge that she can cope with the discomfort, fatigue and itch of this disease, but can't cope with being congratulated and asked her due date every time she goes to the supermarket.

Nevertheless, Gastroenterology is a busy job, and patients are known to deteriorate rapidly, so we often must prioritise the next blood test, cannula, procedure, or scan over discussions about where this is headed if we cannot halt the spiralling decline of their disease course. Whilst focussing on each acute admission and decompensation, we often miss their symptoms, the chance to have meaningful discussions about preferences of care and the opportunity to equip and empower patients and their loved ones. Taking the time and feeling encouraged to have these conversations needs to be prioritised in medical training and considered a vital role of the treating medical team, not just specialist palliative care.

Over 70% of patients with liver disease die in hospital, compared to around 50% of the general population.(3) Factors discussed above such as a unpredictable disease course, social concerns that can be associated with alcohol use and a heavy symptom burden may all contribute to this high percentage of hospital deaths. However, it does raise the question as to whether we are doing enough to facilitate advanced care planning in his cohort of patients.

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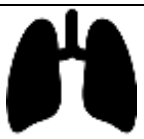
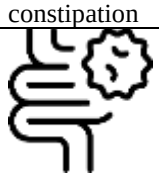
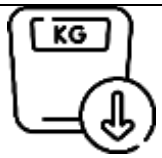
Common symptoms in cirrhosis:

Pain	Breathlessness	Abdominal swelling	confusion	Sleep disturbance	Fatigue	Diarrhoea/ constipation
						
Low mood & anxiety	Cramps	Weight loss	Nausea and poor appetite	Jaundice and itch	bruising & bleeding	Myopathy & weakness
						

General learning points:

- Parallel planning: palliative care, involving symptom management and advanced care planning, is not mutually exclusive with active treatment. Patients can still receive active treatment for their liver disease, in the form of antibiotics, drains and medications, as well as screening for complications such as varices and encephalopathy, whilst also considering their symptoms and how to improve their quality of life.
- Empowering patients and their carers with education about their disease is essential to enable them to meaningfully engage with advanced care planning. Such knowledge can enable early recognition of symptoms and give them time to consider the relative benefits of treatment options available. This may be relatively straightforward to explain, such as or laxatives for encephalopathy, or may involve more complex procedures, such as transjugular intrahepatic portosystemic shunts (TIPSS), both of which can improve symptoms as well as health outcomes.
- Early conversations about disease trajectory are sometimes avoided, as they are deemed pessimistic or difficult, but addressing the possibility of deterioration early can give patients the option to participate in complex decisions about their care. These might include balancing the risk of renal deterioration or infection against the symptomatic relief of ascitic drainage, or the risk of worsening HE with the use of opiates for pain, allowing the patient to personalise and prioritise their treatments.

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Complication specific learning points:

Encephalopathy

- Overt hepatic encephalopathy occurs in up to 50% of patients with liver disease with minimal or covert hepatic encephalopathy reported to occur in up to 80% of such patients.(5)
- Hepatic encephalopathy can have a significant impact not only on patients but also caregivers. Both patients and carers should be equipped to recognise early signs of HE as this will prompt early medical team input to improve quality of life and health outcomes.
- The subtle signs of HE can be particularly easy to miss in patients with alcohol related dementia, where communication with carers is essential to identify signs early.
- Due to HE advanced care planning can be even more important as patients capacity and ability to communicate their wishes may change as their disease progresses.

Ascites

- Ascites is an abnormal accumulation of fluid in the peritoneal cavity.
- Over 50% of patients with cirrhosis develop ascites over a 10-year period of follow-up.
- Poor quality of life - discomfort and pain, difficulty breathing, fatigue, nausea, poor appetite and confusion In refractory ascites, current management involves either TIPSS or serial large volume paracentesis.
- In malignant ascites long term drains are also used – and there is increasing evidence these can be used to manage refractory ascites, which can reduce admissions and symptoms.(6)

Pain:

- Pain is often undertreated in patients with cirrhosis.
- When dosed correctly, paracetamol is one of the safest drugs in cirrhosis. Common practice is to prescribe <2 grams in 24 hours if body weight >50kg.
- Non-steroidal anti-inflammatory drugs should be avoided in all patients with cirrhosis.
- Morphine sulphate is generally considered preferrable to codeine, tramadol, or oxycodone in cirrhosis; specialist pain or palliative care teams should be utilised where possible when prescribing opiates, especially with concomitant renal impairment where prescribing may differ (7, 8).
- Close attention should be paid to opiate related constipation as this increases the risk of HE.

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- Pregabalin and gabapentin are considered safe to use to in cirrhosis, but case reports exist of pregabalin induced hepatotoxicity, so some sources suggest gabapentin should be first line (7, 8).

Pruritis

- Cholestatic itch occurs in a significant number of patients with chronic liver disease, including up to 100% of patients with primary biliary cirrhosis.
- Pruritis can be very distressing and difficult to manage; leading to disturbed sleep, depression, and damage to skin.
- Topical therapies can include emollients to maintain hydration of skin and counter-irritant creams such a menthol 1-2% in aqueous cream.
- Lifestyle measures include keeping fingernails short, wearing cotton gloves at night and avoiding hot baths.
- Oral therapies include selective serotonin reuptake inhibitors (SSRIs) and bile acid sequestrants such as cholestyramine (9).

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