Chronic Liver Disease

Most common causes

In order…

1. Alcohol
2. Non-alcoholic fatty liver disease
3. Viral hepatitides
4. Autoimmune (e.g. autoimmune hepatitis, PBC)
5. Metabolic (e.g. haemochromatosis)

Note: the liver is often not palpable in cirrhosis because it shrinks (splenomegaly more common finding)

Long-term management

- Treat cause
- General
    - Good nutrition
    - Alcohol abstinence
- 6-monthly screen
    - α-FP (monitor for HCC)
    - USS (HCC, hepatic v. thrombus, reversed portal flow)
    - Endoscopy (for varicies)
- Treat/prevent complications
    - Varicies: banding, propanolol
    - Ascites: spironolactone, low salt diet and fluid restriction
    - Encephalopathy: lactulose, rifaximin
    - Coagulopathy: vitamin K

Acute complications

Investigations

- Bloods: FBC, U&Es, LFTs, CRP, coag screen, glucose, blood cultures (if any signs of infection)
- Chest X-ray
- Urine dip and MSU
- Abdominal USS
- Ascitic tap (if ascites present)

Types

1. Decompensation
    - Signs: jaundice, ascites, encephalopathy
    - Causes: SBP/sepsis, dehydration/AKI, UGI bleed/constipation, others (portal vein thrombosis, drugs, liver ischaemia, HCC)
    - Management: treat cause, lactulose/enemas, avoid sedatives, nurse in intensive care if required
2. Hepato-renal failure
    - Worsening renal function in advanced chronic liver disease with no other cause (doesn't respond to fluids)
    - Management: fluid balance monitoring and daily weights, suspend diuretics and nephrotoxic drugs, 5% human albumin solution boluses, arterial vasoconstrictors (e.g. terlipressin)
3. Spontaneous bacterial peritonitis
    - Sepsis/signs of infection in patient with ascites
    - Management: ascitic tap, IV antibiotics, 20% human albumin solution

If history if alcohol excess – prescribe parbinex and chlordiazepoxide for withdrawal