Palliative Care for Decompensated Cirrhosis

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Learning Objectives

1. Recognize the high symptom burden and mortality of decompensated cirrhosis.
2. Understand how palliative care involvement for decompensated cirrhosis patients improves symptom management and documentation of goals of care.
3. Appreciate the benefits of earlier palliative care involvement in the multidisciplinary team.

Case

A 61-year-old female with a history of NASH cirrhosis, morbid obesity, chronic wounds, and refractory ascites was admitted for worsening renal function due to suspected hepatorenal syndrome (HRS). She required frequent paracenteses by interventional radiology (IR) due to body habitus. This was her third admission in two months. Transplant hepatology deemed she was not a liver transplant candidate. Her renal function continued to worsen despite HRS treatment. She had no clear goals of care documented and a poor understanding of her prognosis. She was managed by a multidisciplinary team involving hospital medicine, transplant hepatology, nephrology, and palliative care. Palliative care assessed the patient's unmet needs, including lack of care goals, poor prognostic understanding, and uncontrolled pain. Utilizing the best-case and worst-case framework, a family meeting was held to discuss patient prognosis. This revealed the patient's desire to return home for her remaining days. Palliative care managed her uncontrolled symptoms and discussed the utility of dialysis. She declined dialysis. Prior to discharge to home hospice, IR placed a palliative tunneled long-term peritoneal drain. She died after spending three weeks at home with family.

Hospital Course

61 year old with NASH cirrhosis, HRS, Morbid Obesity, Chronic wounds, DM, and refractory ascites admitted for worsening renal function. This is the third admission in 2 months.

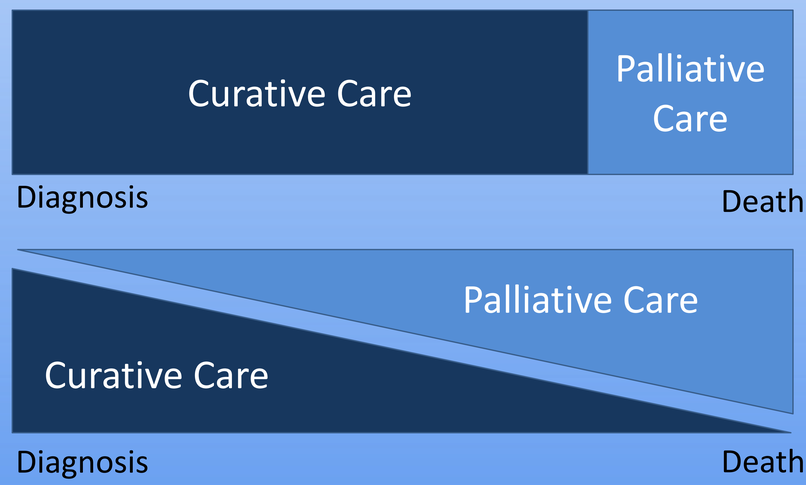
- Uncontrolled Pain, Nausea, pruritus and Anxiety
- Poor Prognostic Understanding
- Lack of care Goals
- Frequent hospitalization and procedures due to ascites

Team based intervention – Hospital medicine, Transplant Hepatology, Palliative care, and chaplaincy

- Symptom management
  - ❑ Opiates for Pain control
  - ❑ Antiemetics
  - ❑ Cholestyramine
- ❑ Prognosis discussion using best case/ worst case framework
- ❑ Patient not a transplant candidate
- ❑ Wants to be home with family and church friends
- ❑ Health care proxy assigned
- ❑ Chaplain to visit everyday in the hospital to pray with her
- ❑ Unable to get paracentesis without IR guidance due to body habitus
- ❑ After risk benefit discussion, Tunneled peritoneal drain placed

Patient discharged with tunneled peritoneal drain, home hospice care. She died in 3 weeks with all the family around her. Was able to spend time with family and friends

Early vs Traditional Palliative Care



Discussion

- The total mortality of liver diseases and cirrhosis surpassed 51,000 deaths in 2020.
- Decompensated cirrhosis is often a terminal illness for patients that do not receive a transplant.
- Palliative care consultation has a positive impact on symptom management and documentation of goals of care.
- Barriers to consultation include misperceptions about palliative care, difficulty estimating prognosis, and the allure of transplant.
- Palliative tunneled long-term abdominal drains can be an effective alternative for drainage of ascites when used in the right setting and patient population, allowing for better symptom management with continuous drainage of small amounts of ascites.

Conclusions

1. Patients with decompensated cirrhosis experience a high symptom burden that is often unaddressed during curative phase of treatment.

2. Earlier utilization of specialist palliative care in a multidisciplinary team model can address the unmet needs of decompensated cirrhosis patients: advanced care planning, symptom management, psychosocial aspects of care, and communication of prognosis.