Jaundice, acute painless (Adult) – Full / Summary clinical guideline

Reference no.: CG-GASTRO/2019/25

1. Summary

This is a practical guideline and check-list for assessing, treating and arranging admission or ambulatory follow-up for adult patients who present to the emergency department (ED) and/or Medical assessment unit (MAU) with acute Jaundice. This guideline applies only to adult patients under the age of 75 years old who have presented via the emergency department or are GP admissions to the medical assessment unit. This is not a direct referral pathway for primary care; who should refer to secondary care either for admission or urgent outpatient review (2-week wait pathway as appropriate).

2. Introduction.

Jaundice is an important clinical finding and needs urgent investigation. This may require inpatient admission but ambulatory patients can have urgent investigations undertaken as an outpatient. This guideline outlines appropriate first line investigations and to which specialty patients should be referred. In addition the guideline outlines the process for referral to Hepatology via the acute jaundice pathway.

3. Aim and Purpose

To offer guidance for all clinical staff treating adult patients with acute jaundice in secondary care.

4. Definitions

- **Acute jaundice** is defined as the onset of jaundice that has been present for less than 28 days in the absence of pre-existing chronic liver disease.
- **Acute Liver failure** is defined as a rapid decline in hepatic function characterised by jaundice, coagulopathy (INR ≥ 1.5) and hepatic encephalopathy or hypoglycaemia (glucose <3.5mmol/L) in patients with no evidence of prior liver disease.
- For patients with **chronic liver disease** please refer to the **Liver Disease- Care Bundle:** **Decompensated Cirrhosis Care Bundle**.

5. Assessment

History: A full medical history should be obtained focusing on the following area as appropriate:

- Constitutional symptoms – fever, rigors, anorexia and weight loss
- Biliary obstruction – pruritus, pale stools,
- Previous cholecystectomy and/or abdominal surgery
- Medication history – Paracetamol, antibiotics, NSAID's, herbal remedies and OCP.
- Illicit drug use – Cocaine, ecstasy, 'legal highs' (e.g. Black mamba)
- Alcohol history
- Recent foreign travel (e.g. risk factors for malaria and dengue)
- Undercooked Pork (hepatitis E) or shellfish consumption (hepatitis A)
- Risks for viral hepatitis – Blood transfusions, IVDU, recent sexual contacts
- Autoimmune conditions or family history
- Exposure to open water (Weil's disease)

- Social circumstances – If chaotic lifestyle (unlikely to attend follow-up)

6. Investigations:

Initial bloods and ultrasound should be requested, as outlined below, by the attending doctor/ACP. NB – serum save sample to microbiology, using a handwritten microbiology form. A serum save sample can subsequently be used to perform viral serology, thus avoiding the need for further phlebotomy.

Initial investigations:

- Bloods: Full blood count, urea & electrolytes, liver function tests, γ-glutamyl transferase, C-reactive protein, conjugated bilirubin, glucose, acute serum save #
- If febrile or features of biliary sepsis obtain blood cultures
- Abdominal ultrasound: principally to exclude biliary obstruction, focal liver lesions and Doppler study of portal and hepatic veins.
- Full acute liver screen**: 'zHep acute hepatitis screen'** (Lorenzo order set) includes Immunoglobulins, Liver autoantibody screen and viral serology including: EBV serology; CMV IgM; Hepatitis B core antibody; Hepatitis B surface antigen; hepatitis E antibodies, HCV RNA PCR; and HIV antibodies.

7. Admissions

Admission to appropriate specialties for adult patients with acute painless jaundice should be as per the jaundice, acute painless (adults) – flow chart below. The management of pregnant women may depend on gestational age and all cases should be discussed with obstetrics in the first instance. Essentially patients should be admitted if the person with jaundice:

- Is acutely unwell
- Has a fever
- Has signs of encephalopathy (such as altered metal state, ataxia or Asterixis)
- Has symptoms and signs of cholangitis (such as fever and RUQ pain/tenderness)
- Is dehydrated
- Has an abnormal clotting profile or shows signs of coagulopathy
- Has abnormal renal function
- Is suspected of having a paracetamol overdose
- Is frail or has significant co-morbidities

8. Ambulatory patients:

Patients should be otherwise self-caring and mobile who do not meet any of the exclusion criteria for the ambulatory acute jaundice pathway and have no other contraindication to ambulatory management. Initial blood should be drawn as outlined, including acute serum save. An abdominal ultrasound scan (USS) should be requested to assess bile duct dilatation, ascites, hepatic and portal vein flow, using one of the ACC slot. The USS should be performed the same day if requested before 2PM, otherwise the patient can return to ACC the following day. Results of initial investigations

should be used to determine the disposition of patient according to the jaundice, acute painless (Adult) flowchart / summary clinical guideline below.

Ambulatory patients should be referred via the acute jaundice pathway on '**Extramed'** system. Referrals will be triaged by a Consultant Hepatologist on a daily basis on weekdays or the next working day if referred over the weekend. Arrangements will be made to see the patient either in clinic or endoscopy within 5 working days. If further imaging is required such as CT/MRCP/ERCP it is the responsibility of the triaging Hepatologist to ensure the correct investigation is requested, however ambulatory care may request appropriate test to expedite investigation. Discussion with a radiologist or the on call gastroenterologists can help identify the appropriate next investigative step.

Ambulatory patients should be given appropriate net information that should include observing for symptoms of biliary sepsis, dehydration and general clinical deterioration and seeking further medical advice in such an eventuality.

9. Treatment:

Please refer to the **Paracetamol overdose** – clinical guideline in suspected cases. For suspected biliary sepsis obtain blood cultures and refer to **biliary tract infections - antibiotic guidelines.**

Jaundice, acute painless (Adult) – Flowchart

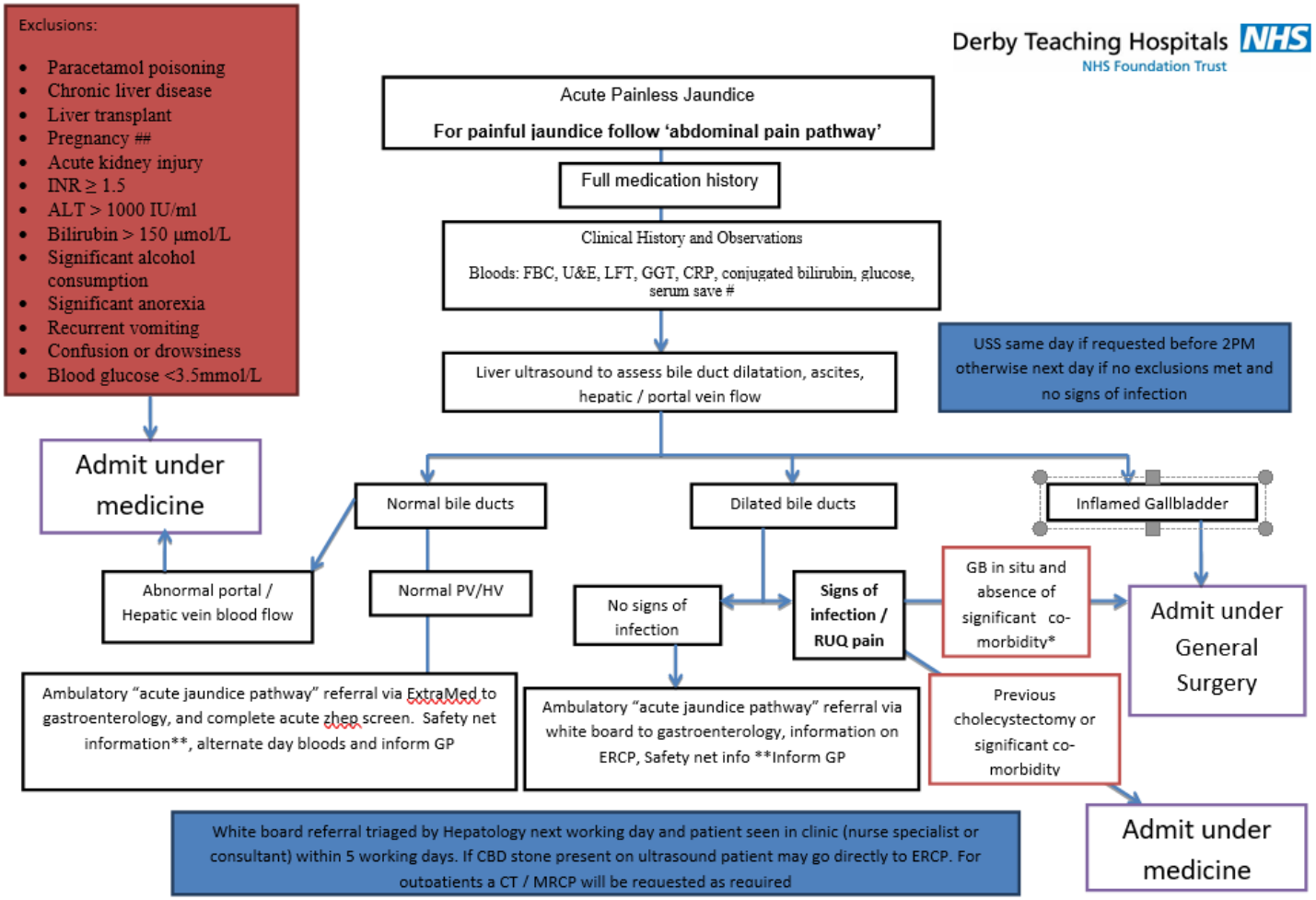
*Significant cardio-respiratory morbidity that would preclude operative management if unsure please discuss with on call surgical registrar.

** Ambulatory patients should be given appropriate safety net information that should include observing for symptoms of biliary sepsis, dehydration and general clinical deterioration and seeking further medical advice in such an eventuality. Admission should be organised if they subsequently meet exclusion criteria.

A Serum save sample should be obtained and send to microbiology using a handwritten microbiology form (Avoids further phlebotomy if viral serology subsequently required)

The management of pregnant women may depend on gestational age and all cases should be discussed with obstetrics in the first instance.

Jaundice, acute painless (Adult) – Flowchart / Summary clinical guideline



Documentation Controls (these go at the end of the document but before any appendices)

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Version / Amendment History	Version	Date	Author	Reason
	2	2022	Liver Management group	Previous version of guideline expired
Intended Recipients: State who the Clinical Guideline is aimed at – staff groups etc. All clinicians caring for adult patients				
Training and Dissemination: How will you implement the Clinical Guideline, cascade the information and address training The guideline has previously been promoted to admitting teams on MAU and SAU				
Development of Guideline: **Job Title: Dr N Taylor, Consultant Hepatologist**				
Consultation with: Liver management group				
Linked Documents: State the name(s) of any other relevant documents Decompensated cirrhosis care bundle Paracetamol overdose guideline Biliary tract infections – antibiotic guidelines				
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