Palliative and Symptom-focused Care in Advanced Liver Disease – Full Clinical Guideline

Reference no:CG-CLIN/4221/23

Advanced decompensated cirrhosis is associated with a poor prognosis, comparable to that of most advanced cancers. Despite this, many patients have no input from specialist palliative care in the last months of their life despite a significant symptom burden. The vast majority of patients will die in hospital after an emergency admission.

Identifying patients with a poor prognosis in the outpatient setting who would benefit from advanced care planning and parallel symptom-focused care can be challenging. The following clinical indicator tools have been demonstrated to be effective in identifying those with a prognosis of less than one year with a PPV of over 80%.

Bristol Screening Tool	**SPICT**
3 or more of: • Child Pugh Grade C • >1 liver related admission in last 6 months • On-going alcohol use (in ARLD) • Unsuitable for transplant work-up • WHO performance status 3-4	Cirrhosis with one or more complications in last year: · Diuretic resistant ascites · Hepatic encephalopathy · Hepatorenal syndrome · Spontaneous Bacterial Peritonitis · Recurrent variceal bleeding In those for who transplant will not be a possibility

If these tools apply then the following should be considered:

· Poor prognosis discussion with patient/family
· Discussion in the advanced liver disease MDT (held on 2nd Thursday 1-2pm each month)
· Poor prognosis letter to GP
· Advanced care planning discussion
· Referral to palliative care specialist
· Allocation to a named hepatologist for co-ordination of care

Advanced care planning allows patients and their carers to set goals of care and enables shared-decision making. This is still appropriate in the setting of ongoing active management of liver disease.

This may include:
• Shared decision making for future treatment:
- Screening - varices/HCC
- Emergency complications
- The possibility of long-term ascitic drain
- Preferred place of death
- DNACPR/ceilings of care
- Advanced planning for deterioration e.g. allocating a Power of Attorney for health decisions, will-writing

• Education
- Complications of liver disease
- Management of symptoms

- Onward referral to specialist/community services
- Palliative care
- Community nursing teams
- Financial support
- Social services/benefit support

Symptom enquiry and initiation of measures to improve symptom control is within the remit of Hepatology care. Selected patients will require referral to specialist palliative care for complex symptom management.

BASL have produced a comprehensive document outlining pharmacological treatment for common symptoms and anticipatory prescribing at the end of life. These are summarised below:

Anticipatory Prescribing

Symptom	**Drug and dose**		**Usual starting dose for syringe driver (over 24 hours)**
Pain	If eGFR >30	**Morphine Sulphate 2.5mg SC hourly**	Use PRN for 24 hours to establish requirement
	If eGFR<30	1st line**: Fentanyl 12.5-25 micrograms SC hourly** 2nd line: **Alfentanil 50-100 micrograms SC hourly**	
Agitation	**Haloperidol 0.25-5mg SC TDS** – first line if confusion-induced		1-1.5mg
	Midazolam 1.25-2.5mg SC 2 hourly – first line if anxiety-induced		5-10mg
	2nd line: **Levomepromazine 2.5mg SC TDS**		6.25mg
Nausea and vomiting	Opioid or centrally-induced (e.g. profound jaundice	1st line: **Haloperidol 0.25-0.5mg SC TDS**	0.5-1.5mg
		2nd line: **Levomepromazine 2.5mg SC TDS**	6.25mg
	Prokinetic	**Metoclopramide 5mg SC TDS**	15mg
Dyspnoea	Morphine/fentanyl – see doses for pain		
	If associated respiratory panic: Can swallow: **Lorazepam 0.5-1mg PO/SL 4-6 hourly**		N/A
	Can't swallow: **Midazolam 1.25-2.5mg SC hourly**		5-10mg
Respiratory secretions	1st line: **Hyoscine hydrobromide 20mg SC 2 hourly**		60mg
	2nd line alternative: **Glycopyrronium 200 micrograms SC 2 hourly**		600micrograms

Common symptoms and prescribing in Child B/C cirrhosis

Symptom	Drug and dose		Notes
Pain	1st line: **Paracetamol 2-3g/24 hour PO,** if IV maximum 2g/24 hours (doses of 500mg)		If over 50kg 1g QDS is safe for short periods (<7 days). Avoid IV preparation whenever possible and always dose reduce to 500mg when prescribing
	2nd line: **Morphine sulphate 2.5mg 4-6 hourly PO PRN**		1st line opioid for pain if eGFR>30. Use short-acting preparations where possible. Monitor closely for constipation and encephalopathy
	If eGFR<30 1st choice opioid is hydromorphone although this is not readily available. Discuss with local pharmacist for long-term alternatives		Avoid NSAIDs and amitriptyline. Avoid codeine, oxycodone where possible as half-life significantly prolonged.
Itch	1st line: **Menthol 1% in aqueous cream**, apply 1-2 times daily		
	2nd line: **Cholestyramine 4-8g PO OD**		Affects absorption of other medications – take other medications at least 1 hour before or 4-6 hours after.
	Other medications: Antihistamines, rifampicin, naltrexone (see section Management of Pruritus in Cholestatic Liver disease for further details)		Antihistamines are generally ineffective for itch due to cholestasis but may have a helpful sedative effect if used at night. However, they can worsen encephalopathy.
Nausea and vomiting	GI causes (e.g. gastroparesis, ascites, constipation)	1st line**: Metoclopramide 5mg PO/IV/SC TDS**, titrate to 10mg TDS	May cause QT prolongation
		2nd line: **Domperidone 5mg PO BD**, titrated to 10mg TDS	May cause QT prolongation
	Opioid-induced or central causes (e.g. profound jaundice)	1st line: **Haloperidol 0.5-1mg PO BD** or **0.25-0.5mg SC TDS**	
		2nd line: **Ondansetron 4mg PO/IV BD**, maximum dose 8mg/24 hours	Can cause constipation.
		3rd line: **Cyclizine 50mg PO BD** or 25mg IV/SC BD	Avoid if possible, monitor for constipation and encephalopathy
Depression	1st line: **Mirtazapine 15mg PO ON**, titrate slowly to maximum dose 30mg ON		Avoid in renal impairment. May have sedating effect.
	2nd line: **Citalopram 10mg PO OD**, titrate slowly to maximum 20mg OD		Can lower seizure threshold (avoid if history of seizures) and may increase GI bleeding risk

Further Reading:
Symptom control and end of life care in adults with advanced liver disease. BASL Guideline 2018.
Palliative care in liver disease: what does good look like? Woodland et al. Frontline Gastroenterology 2020;11: 218-27

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

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