lives of people with alcohol-related liver disease (ARLD) by failing to provide early intervention and specialist consultant input.1

Methods We aimed to review the management of patients with decompensated liver disease in the first 24 h after admission to hospital. This was a region-wide audit including all Trusts in the Northern Deaneary. An audit proforma was designed and data collected on consecutive admissions over a 3 month period.

Results 139 patients were included in the study; 69% male, median age 54 years (range 26–86 years). ARLD was the cause of liver disease in 88%. The median MELD score was 19 (range 6–39) and 88% had Child-Pugh Grade B or C disease. The commonest reasons for admission were ascites (28%), GI bleeding (21%), encephalopathy (19%) and jaundice (16%).

There was a 9% mortality rate during the admission and average length of stay was 15 days.

82 patients had clinical ascites; 62% had a diagnostic tap within 24 h of admission, 21% waited >24 h and 17% did not have a diagnostic tap. 18% had spontaneous bacterial peritonitis (SBP).

Previous alcohol history was only documented in 43% but current daily consumption was documented in 81%. Of patients with documented current alcohol excess, 92% received parabine and 94% were started on CIWA.

99% had their renal function checked on admission. 26% had renal impairment; 28% of whom did not have all their nephrotoxins stopped. Hypernatraemia (sodium <125 mmol/L) was present in 9%; 42% of whom did not have diuretics stopped.

27 (19%) patients had known or suspected variceal bleeding. 19% did not receive terlipressin and 30% did not receive vitamin K. 67% of patients had an upper GI endoscopy within 12 h of admission, and 78% within 24 h.

Hepatic encephalopathy was present in 32% of patients and lactulose commenced in 98%.

17% of patients were not seen by a consultant (any speciality) within 12 h of admission, 7% were not seen by a gastroenterology or hepatology consultant within 72 h of admission and 39% were not seen within 24 h.

Conclusion There are clear deficiencies in the acute management of these patients and we are instituting a care bundle to focus on the key management of these patients and guide clinicians to improve patient care. We will re-audit to assess the impact of the ‘care bundle’ on patient care.

REFERENCE

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