ACLF MEETING

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- Mr G J, 58 year male.
- No comorbidity.
- History of significant alcohol intake.
- Abstinence since last 10 days before admission.
- Now admitted on 11/03/2022 – with complaints of Jaundice since 10 days , abdominal distension since 5 days and disoriented since 1 day.

- According to APASL criteria – presentation was like ACLF

- On admission – conscious but drowsy, obeying commands – flaps + (grade 2 HE)
- Ascites +. No SBP.
- No hypotension , no hypoxia, no GI bleed.
- Creatinine – 2.8, INR – 3.2 , Total bili – 36, CRP – 48.
- **MELD–Na – 42.**

AARC SCORE

- Total bilirubin – 36 (3 points)
- HE Grade 2 (2 points)
- INR – 3.2 (3 points)
- Lactate – 2.6 (3 points)
- Creatinine – 2.8 (3 points)
- **AARC SCORE – 14**
- **ACLF Grade III**

WORK UP

- USG abdomen with portal Doppler – Liver cirrhosis, no SOL , splenomegaly, no collaterals, no PVT, mild ascites.
- MRI Abdomen plain – Features of CLD with portal hypertension resulting in splenomegaly, ascites and collaterals. Large gastrorenal shunt noted opening into the left renal vein. Tiny T2 hyperintense focus is seen in the subcapsular aspect of segment 8/5 of right lobe of liver. It is likely to represent a benign lesion, most likely a cyst. Signal void of main portal vein is well appreciated however appears attenuated.

TREATMENT

- Started on Inj Meropenem, terlipressin and albumin.
- Blood and urine cultures sent.

- Blood culture – No growth
- Urine culture – Enterococcus , 10000 CFU – was started on Inj Tigecycline based on sensitivity report.

COURSE IN WARD

- During the course of hospital stay – patient had RHQ and epigastric pain, non radiating, not related to meals – hence Inj Terlipressin was stopped in between.
- Pain was slightly better but not fully controlled and required frequent analgesics.
- Later on Inj Terlipressin was restarted in reduced dose and as bolus injections (rather than continuous infusion).

	DAY 1	DAY 7	DAY 10	DAY 14
CREATININE	2.8	2.7	1.6	1.5
T BILIRUBIN	36	32	16	12
INR	3.2	3.0	2.8	2.4
HE	GRADE 2	0	0	0
CRP	48	46	38	33
MELD-Na	42	40	35	32

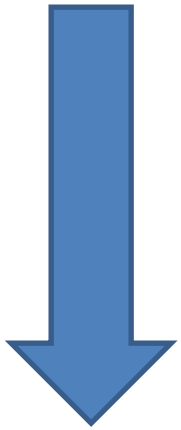
- Psychiatric evaluation was done.
- Patient improved on antibiotics and terlipressin. However creatinine did not return to baseline and any reduction in dose of terlipressin caused creatinine to rise again
- **MELD–Na – 32 now.**

ISSUES

1. **Non abstinent severe alcoholic hepatitis - ? Can we transplant.**
2. **ACLF with high MELD-Na – Steroids Vs Plasmapharesis Vs Transplant.**
3. **IF TRANSPLANT CONSIDERED - Pre-transplant optimisation strategy**
4. **Post transplant counselling.**

OUR STRATEGY

MELD-Na > 30 WITH ACLF WITH ORGAN FAILURE



UPFRONT TRANSPLANT

- Underwent LDLTx on 29/03/2022.
- Post operative course was uneventful except o pus drainage from surgical wound on day 5– culture grew Klebsiella Pneumoniae (MDRO) – antibiotics were upgraded to Ceftazidime + Avibactam and Aztreonam.
- Post transplant stay was for 15 days
- Recovery uneventful.

CULTURES

DATE	TEST	RESULT
29/03/22	CRE	Positive
29/03/22	VRE	Positive
29/03/22	Blood C/S	No Growth
29/03/22	Urine C/S	Yeast isolated
04/04/22	Wound swab c/s	KP MDRO
04/04/22	CMV DNA Qualitative	Not detected
05/04/22	Carba R	Not Detected

- Patient was discharged on Triple immunosuppression.
- Tab Tacrolimus 1mg 1-0-1.
- Tab Mycophenolate Mofetil 1000mg 1-0-1.
- Tab Wysolone 20mg 1-0-0.
- Tab Ecospirin 75 mg 0-1-0.

THANK YOU