DECOMPENSATED CIRRHOSIS: TO TREAT OR NOT TO TREAT

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CONFLICT OF INTEREST

• None
• Don’t have any
• Zero
• Negatory
DECOMPENSATED CIRRHOSIS: OBJECTIVES

- Who is too sick to treat?
- MELD
  - 15+ should be seen by transplant service
  - <18 may benefit from treatment

JIM

- Nice guy
- Married, kids

Risk factors for HCV
- Born in Greece, immigrated to Canada in 1963
- Cocaine, 1980's
- Lifestyle
  - retired, used to have 1-2 drinks/day from age 25-2017, smoked 1 ppd from age 17-46 yo
CASE STUDY

Patient: 66yo, male
- GENO 1a
- VL 9.27 E5 IU/mL

Lab work
- ALT 84, AST 141 (<2:1 ratio = cirrhotic)
- INR 1.73, ALB 28, Bili 46
- PLT 52
- CRE 74

CO-MORBIDITIES

- Prior Cholestectomy
- BPH
- TURP 2017
- Ascites

Medications:
- Nadalol 40 mg
STUFF

- Baseline MELD 14
- CP score was B-9

So what factors do we look at?
- (Based on Astral 4) ALT/AST elevated: Yes
- MELD under 18: yes
- Technically people with all these predictive factors in place should have a good outcome and benefit from treatment with a DAA

Increased caffeine consumption is associated with reduced hepatic fibrosis

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WOULD YOU TREAT THIS PATIENT?

Quick recap- Geno 1a, VL 9.27 E5, decompensated cirrhosis with MELD 14, CP B9 with ascites

Yes – he was treated

November 2017 started treatment with Sofosbuvir/Ledipasvir x 12 weeks
**PATIENTS WITH DECOMPENSATED CIRRHOSIS WHO HAVE GENOTYPE 1, 4, 5, OR 6 INFECTION AND ARE RIBAVIRIN ELIGIBLE**

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<th>RATING</th>
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<td>Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) with low initial dose of ribavirin (600 mg, increase as tolerated)</td>
<td>12 weeks</td>
<td>I, A²</td>
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<td>Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg) with weight-based ribavirin¹</td>
<td>12 weeks</td>
<td>I, A¹</td>
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AASLD HCV Guidelines

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**PATIENTS WITH DECOMPENSATED CIRRHOSIS WHO HAVE GENOTYPE 1, 4, 5, OR 6 INFECTION AND ARE RIBAVIRIN INELIGIBLE**

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Recommended regimens listed by evidence level and alphabetically for: Patients With Decompensated Cirrhosis Who Have Genotype 1, 4, 5, or 6 Infection and Are Ribavirin Ineligible
SVR ACHIEVED

RESULTS

SVR Post Treatment blood work
• ALT 21
• MELD 12
• CP B-9

POST TREATMENT

• When he was discharged from his previous treatment team, it was based on a successful SVR outcome, despite the worsening ascites and other symptoms
• January of 2018, he presented to TGH a host of serious complications:
  • Sarcopenia: no muscle mass, thin, wasted
  • Developed a right hepatic hydrothorax
POST TREATMENT MANAGEMENT

Treating the Sarcopenia:

• A tap showed fluid was cloudy
  • Not infected but 1.17 fluid triglycerides
  • Fats are absorbed via lymphatics, spilling into ascites fluid
• Patient met with a Registered Dietician and underwent many dietary modifications of dietary fats
  • Load up on mid-chain fatty acids. Eg. Coconut oil, or if not available, olive oil
• Aim for high protein, high calorie diet
  • Reduced protein used to be recommended but it makes sarcopenia worse, increasing mortality

HEPATIC HYDROTHORAX

• Usually right sided
• Defect in diaphragm allows communication between chest and abdomen
• Breathe in
  • Draw fluid up to chest
• Breathe out
  • Increase chest pressure, closes tissue valve
  • Traps fluid in chest
POST TREATMENT MANAGEMENT

• Unfortunately, the patient requires regular weekly Thoracentesis
• Nutritional status improved with taps but unable to stop taps
• =No QOL

• Assessed for TIPS to manage the hydrothorax
• Echo was done
• TIPS booked for Feb 14

TAKE AWAY

• His #'s sound impressive, but in real life, not all roses
• It was hoped that post SVR, he would improve however,
• SVR ↓ MELD to 12= eliminates patient as a transplant candidate
• Low MELD = MELD purgatory

SVR is not the end all/be all
• Still have to manage the complications of a decompensated cirrhotic patient
• Pre-treatment, this patient never required a tap, now he’s post-treatment weekly tap.
• Quality of life?
MORE TAKE AWAY MESSAGES

• His predictors pointed to a good outcome but be aware that there is a possibility of worsening of symptoms
• Management of the often complex medical needs even after achieving SVR
• the estimated 1- and 5-year survival rates are 95% and 75% for patients with Child-Pugh class B, and 85% and 50% for patients with Child-Pugh class C.
• After the onset of the first major medical complication (ascites, variceal bleeding, jaundice, or encephalopathy), survival rates for these patients are significantly reduced.

• Recognize the appropriate timing for referral to an Hepatologist

I TOTALLY POACHED THIS SLIDE FROM DR. SAM LEE’S PRESENTATION YESTERDAY
HAVE A SAFE TRIP HOME!