

An aerial photograph of a coastal town, likely Laguna Niguel, California. The image shows a dense residential area with many houses built on a hillside overlooking a sandy beach. The ocean is a vibrant blue, and the sky is clear. In the foreground, there are lush green lawns and numerous tall palm trees. The overall scene is bright and sunny, suggesting a pleasant climate.

2022 SCSG LIVER SYMPOSIUM

DECEMBER 17 - 18, 2022

THE RITZ CARLTON, LAGUNA NIGUEL



AASLD Guidance on Palliative Care and Symptom-Based Management in Decompensated Cirrhosis

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Disclosures

- None to report

Overview

1. **Key Concepts Related to Palliative Care**

- Review of definitions and evidence

2. **Overview of Guidance and Key Recommendations**

- Review of specific gaps in palliative care needs
- Resources for Integrating Principles of Palliative Care

Overview

1. **Key Concepts Related to Palliative Care**

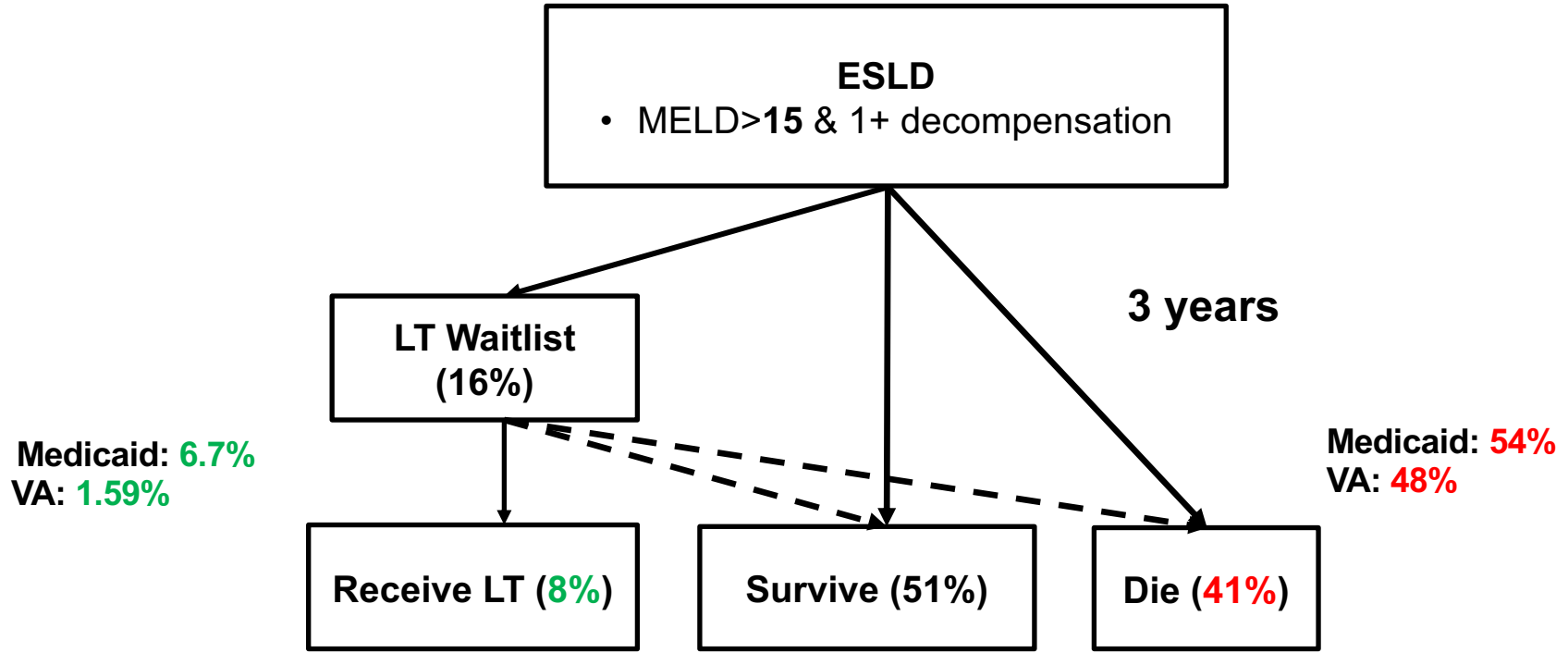
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3. **Resources for Integrating Principles of Palliative Care**

Limited Options for “Cure” in Decompensated Cirrhosis



Decompensated Cirrhosis as a “Serious Illness”

High risk of mortality



**Excessively
strains
caregivers**



**Negatively impacts
quality of life**



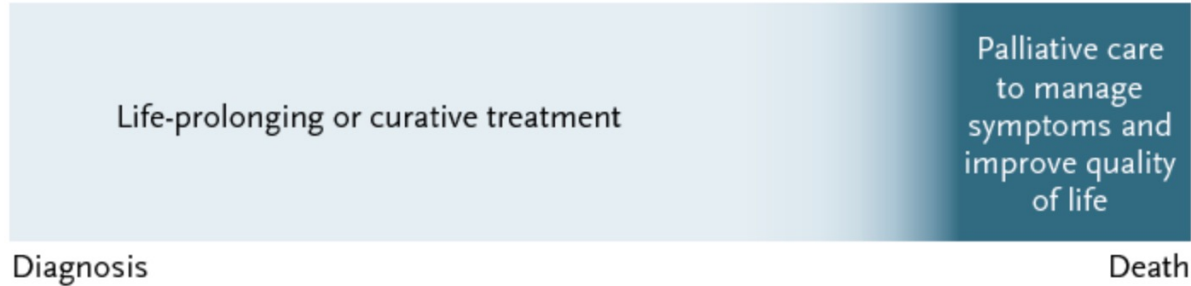
Definition of Palliative Care

Active holistic care of individuals with serious health-related suffering due to severe illness and especially those near end of life.

Aims to improve **quality of life** of patients, their families, and their caregivers



Traditional Palliative Care



Traditional

Early Palliative Care



Contemporary

What Do Palliative Care Teams Do?

Physical Symptoms

Psychological Aspects of Care

Advance Care Planning

Social and Cultural Issues

Spiritual, Religious,
and Existential Issues

End of Life Care

Not just this!

“Specialty” Palliative Care

- Interdisciplinary team (IDT)
 - Clinician, Nurse, Social worker, Chaplain, Pharmacist, and others
- Comprehensive assessments, care in every setting, continuity

“Primary” Palliative Care

- Clinicians trained in basic principles of PC.

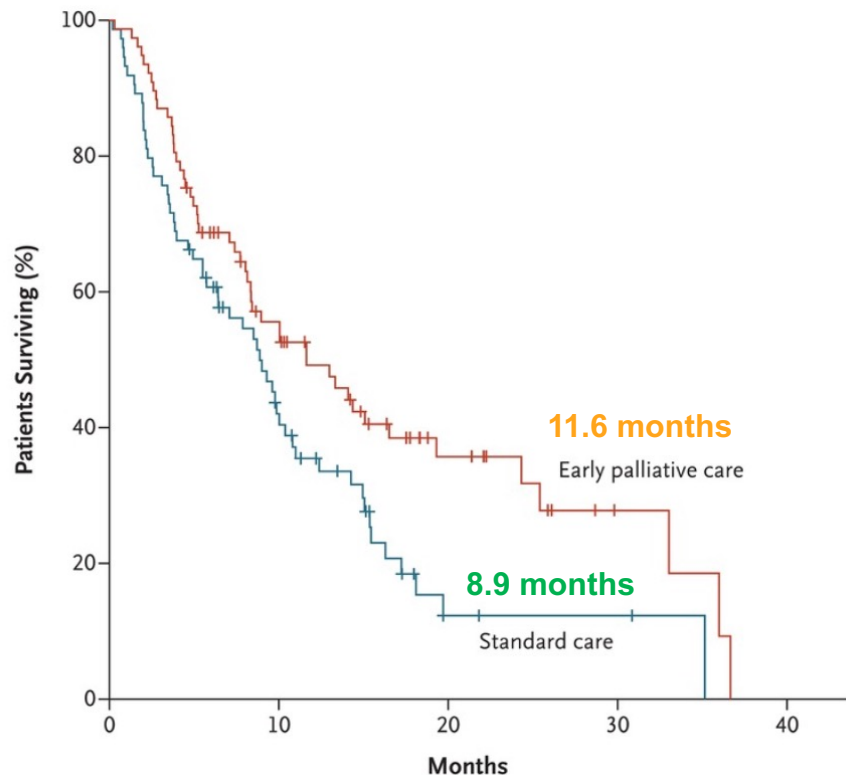
Early Palliative Care for Metastatic NSCLC

- N=151 patients, RCT, standard care vs. standard care with early **palliative care** (PC) – monthly visits.

Variable	Standard Care (N=47)	Early Palliative Care (N=60)	Difference between Early Care and Standard Care (95% CI)	P Value†
FACT-L score	91.5±15.8	98.0±15.1	6.5 (0.5–12.4)	0.03
LCS score	19.3±4.2	21.0±3.9	1.7 (0.1–3.2)	0.04
TOI score	53.0±11.5	59.0±11.6	6.0 (1.5–10.4)	0.009

Lower rates of **depression** (16 vs. 38%) at 12 weeks

Early Palliative Care for Metastatic NSCLC

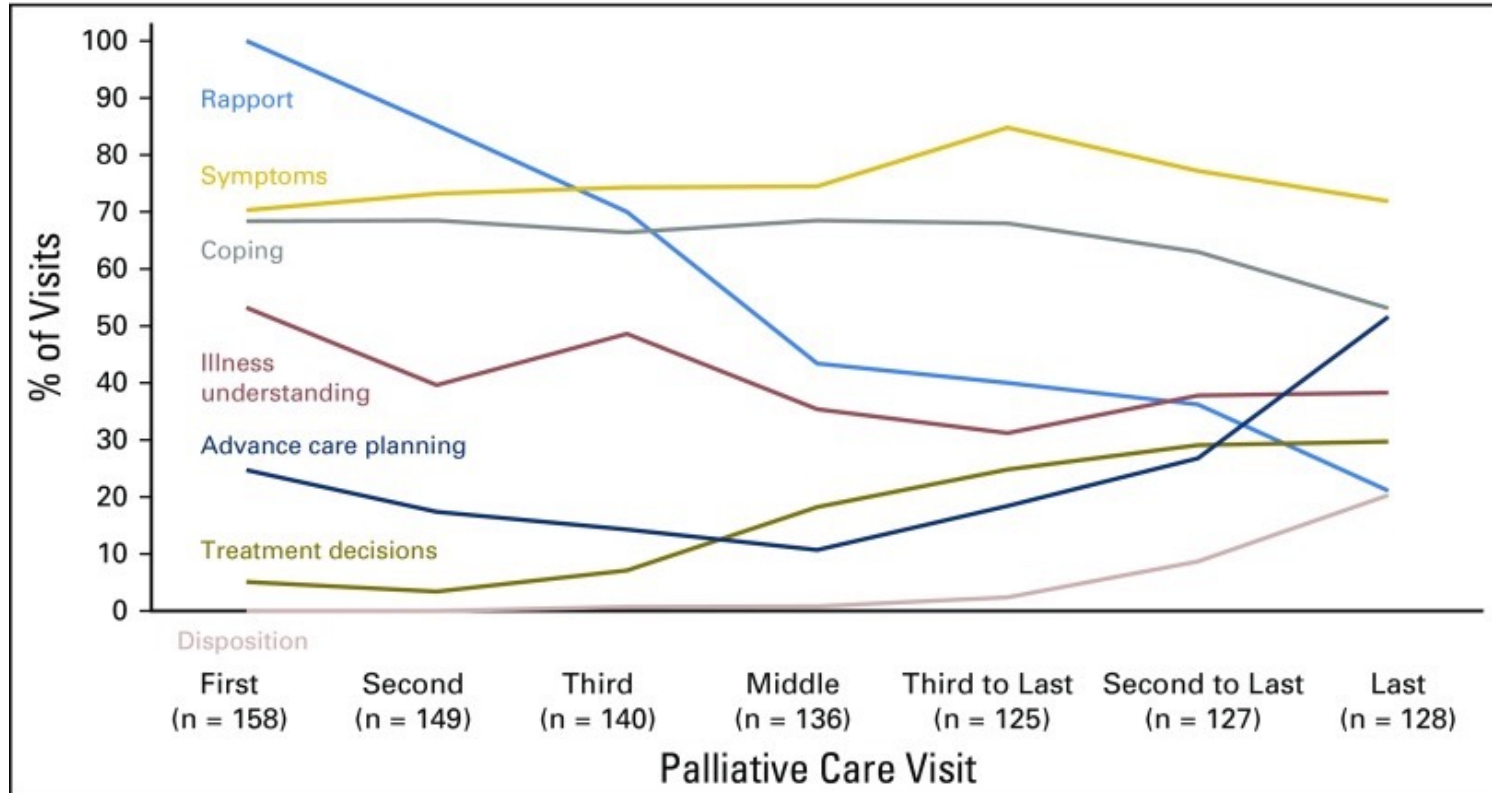


...And lived longer!

with

Lower rates of aggressive care
at the End of Life (**33%** vs. **54%**)

What Did Palliative Care Teams Actually Do?



Key Definitions in AASLD Guidance

	Primary palliative care	Specialty palliative care	Hospice	Advance care planning
Primary focus	Quality of life, symptoms, psychosocial and spiritual support	Quality of life, symptoms, psychosocial and spiritual support	Quality of life, symptoms, psychosocial and spiritual support	Longitudinal process of discussing and documenting patient values and preferences around their care (e.g., end of life); identifying surrogate decision makers
Delivered by	Primary or specialist treating teams	Palliative care clinicians/ teams, as consultants or embedded within practices	Usually private hospice agencies (or within Veterans Administration system for veterans)	Any clinician; persons can also complete some documents on their own.
Timing	Any time a need is identified	Any time a need is identified	Prognosis ≤ 6 months	Can be addressed early in the illness course and revisited on a regular basis and when there are major clinical changes
Location	Anywhere under the care of treating team	Inpatient, outpatient, community (home, nursing home)	Home, nursing home, inpatient (limited time for uncontrolled symptoms)	Anywhere
Reimbursement	Routine CMS billing	Routine CMS billing	Capitated payment model through Medicare Part A	Can be reimbursed with ACP billing codes: 99497 (first 30 min) 99498 (additional 30 min)

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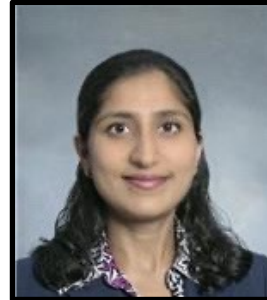
3. Resources for Integrating Principles of Palliative Care

AASLD Practice Guidelines Committee: “The idea was to identify emerging topics in hepatology that our members needed to know about...In hindsight this was a **no-brainer** and **long overdue.**”
(**George Ioannou MD MS**)



Our Team

Shari Rogal, Lissi Hansen, Christopher Woodrell, Manisha Verma,
Nneka Ufere, Arpan Patel, Fasiha Kanwal



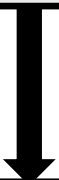
Process for Guidance Development

Guideline	Supported by systematic review , formal ratings of quality/strength, meta-analyses using GRADE
Guidance	Consensus of an expert panel based on formal review and analysis of literature

National Consensus Project Guidelines for PC



**Individual Literature Reviews
with Guidance Statements**



**Group Discussions to Generate Key
Figures/Tables and Points of Emphasis**

Effectiveness of PC in Cirrhosis, Other Populations

Advance Care Planning, Communication*

Symptom Management*

Psychosocial, Spiritual, Cultural Aspects of Care

End of Life Care

25 pages, 66 guidance statements (!)

Decreased Patient AND Caregiver Physical and Mental Quality of Life

	Physical quality of life (Model 1)		Mental quality of life (Model 2)	
	Patient B (SE)	Caregiver B (SE)	Patient B (SE)	Caregiver B (SE)
Patient characteristics	33.53 (0.88)	48.69 (0.05)	42.89 (1.00)	45.83 (0.99)
Gender (women)	1.76 (1.95)	2.82 (1.96)	-1.73 (2.07)	0.32 (2.31)
Age	0.13 (0.08)	-0.20 (0.08) ^a	0.26 (0.08) ^b	0.14 (0.09)
Years of cirrhosis	-0.16 (0.13)	-0.19 (0.13)	-0.16 (0.14)	-0.01 (0.15)
MELD-Na	-0.25 (0.19)	-0.13 (0.19)	0.03 (0.21)	0.04 (0.23)
Charlson Comorbidity Index	0.18 (0.42)	-0.50 (0.43)	0.25 (0.44)	0.16 (0.50)
Hepatic encephalopathy (^c managed vs no history)	-3.86 (1.65) ^a	0.88 (1.67)	-2.02 (1.76)	-0.81 (1.97)
Ascites (managed vs none)	-3.47 (1.83)	-1.94 (1.85)	-3.15 (1.94)	-1.98 (2.18)
Ascites (refractory vs none)	-9.19 (2.28) ^d	-5.41 (2.33) ^a	-3.46 (2.42)	-1.86 (2.75)
Uncertainty	-0.14 (0.05) ^b	0.06 (0.05)	-0.31 (0.06) ^c	-0.15 (0.06) ^a
Relationship quality	-3.26 (1.33) ^a	1.91 (1.37)	1.69 (1.41)	1.94 (1.61)
Caregiver characteristics				
Gender (women)	3.09 (2.20)	0.96 (1.37)	-3.05 (2.34)	-0.56 (2.61)
Spouse caregiver	2.34 (1.82)	1.48 (1.86)	-2.46 (1.94)	-5.04 (2.19) ^a
Uncertainty	-0.10 (0.06)	-0.16 (0.06) ^b	0.06 (0.06)	-0.02 (0.07)
Relationship quality	0.66 (1.12)	-0.19 (1.13)	2.73 (1.19) ^a	2.51 (1.33)

Key Acknowledgements, Role of Caregivers

1. Palliative care can be provided to patients with DC at any stage of their illness.
 2. Palliative care can be delivered by any member of the care team (primary palliative care) as well as teams with subspecialty training (specialty palliative care) for more-complex cases.
 3. Palliative care does not preclude the delivery of disease-directed or even curative treatments.
 4. Hospice is different than palliative care in that it focuses exclusively on comfort, rather than disease-directed curative treatment, and includes only persons with life expectancy measured in months.
-
1. Caring for caregivers is a central component of providing palliative and hospice care.
 2. Caregiver support should be provided across the trajectory of liver disease and is critically important in the context of DC, EoLC, and after the patient's death.

Patients With Cirrhosis and Their Caregivers Have High Informational Needs

Participants

1,413 patients

Qualitative n = 78
Quantitative n = 1,335

31 family carers

733 health professionals

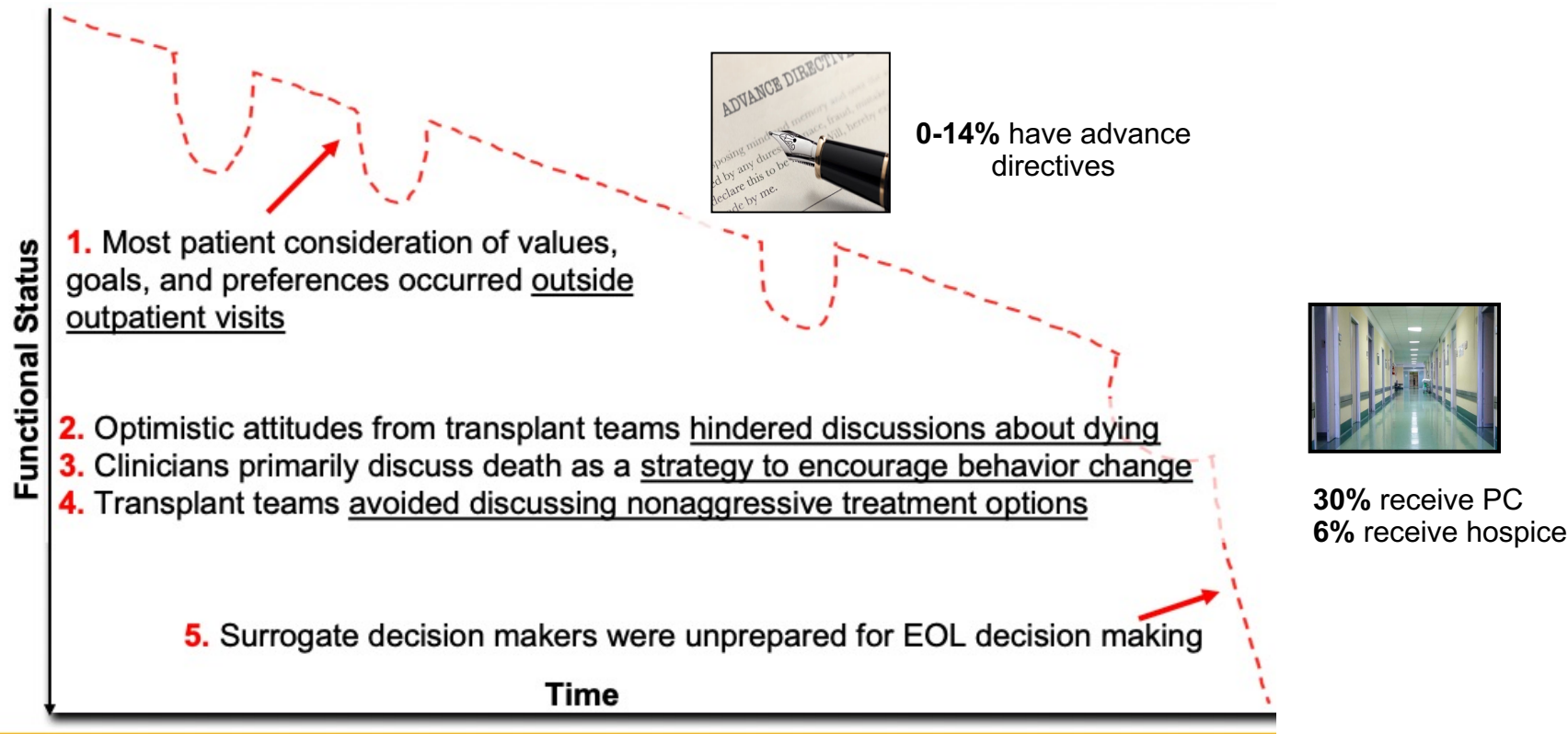
Qualitative n = 88
Quantitative n = 645

Key findings

- Limited understanding about cirrhosis and its impact
- Better information needed about liver disease and associated treatments
- More information needed about how to obtain psychological and practical support

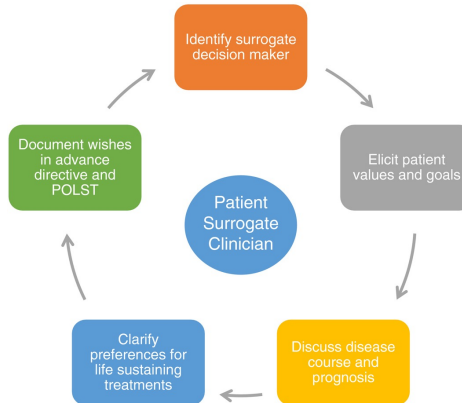
- Difficulty in communicating to patients about cirrhosis and its impact
- Lacked confidence discussion prognosis or future care preferences
- Poor continuity of care between primary care and liver teams
- Palliative care recognised as having important role in liver care

They Experience Significant Gaps in Advance Care Planning and End of Life Care

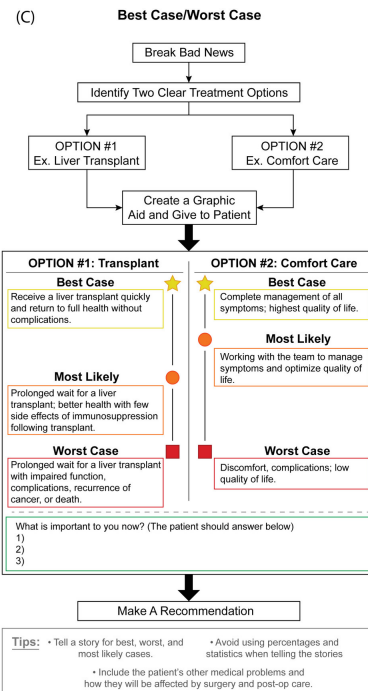
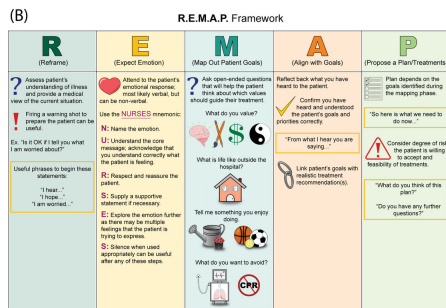
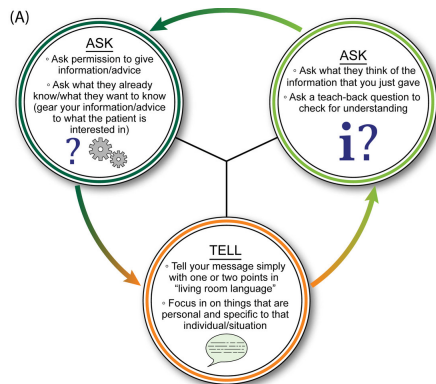



ACP and Serious Illness Conversations

1. ACP is an iterative process that should start with a diagnosis of cirrhosis and preferably occur before hepatic decompensation and loss of decision-making capacity.
1. Structured communication frameworks can be used to communicate uncertainty, discuss serious news, and establish a plan of care that is aligned with patient values.
2. Serious illness conversations should occur in the language preferred by the patient and their family. Medical teams should use a professional medical interpreter to facilitate these conversations.



Serious Illness Communication Skills Programs and Structured Communication Frameworks




 Clinician confidence
 Clinician skills
 Documentation
 Quality of documentation
 Patient-surrogate congruence

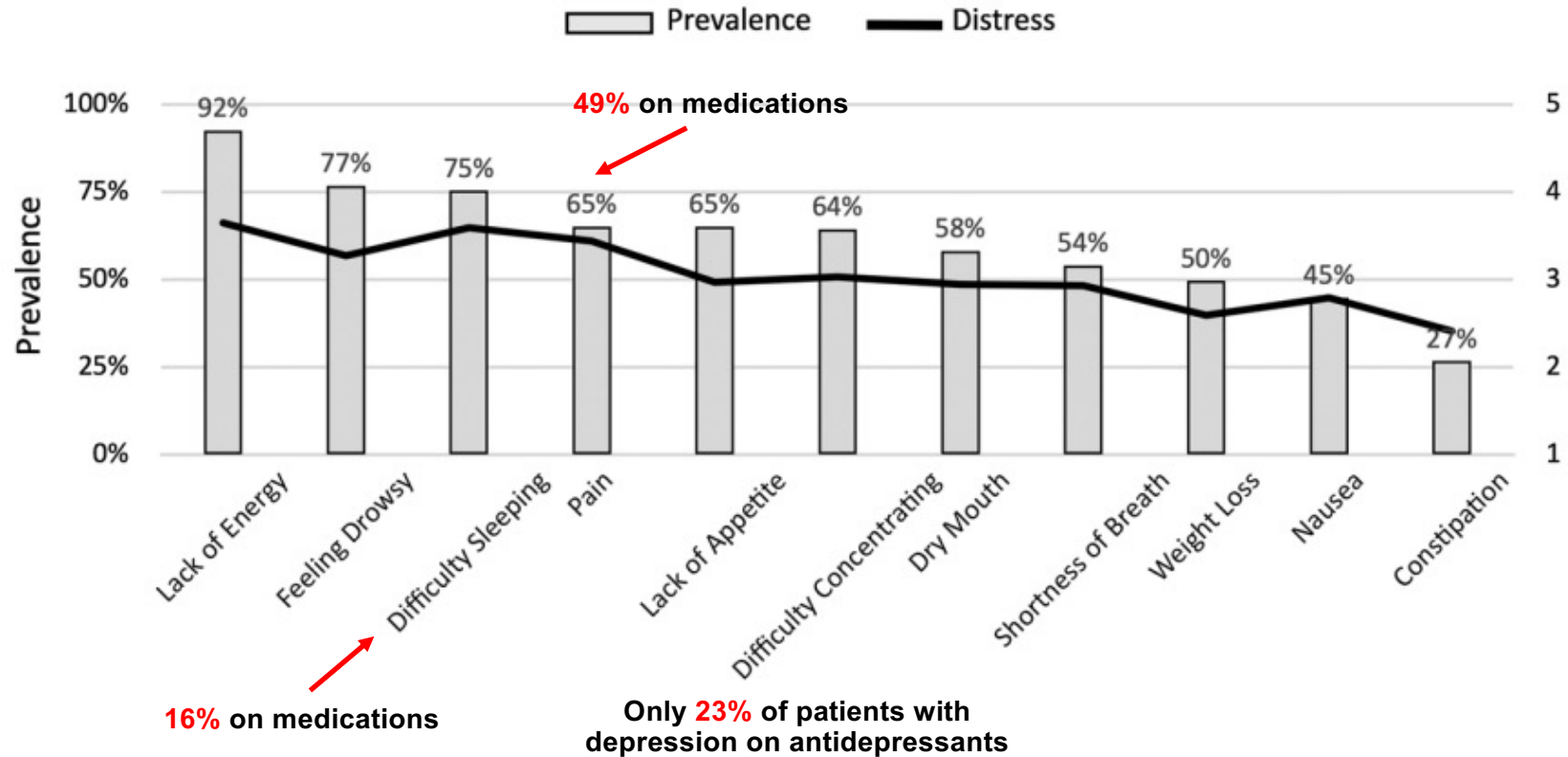
Symptom Burden Is High in Decompensated Cirrhosis

Symptom	ESLD	Cancer ^a	COPD ^a	CHF ^a	ESRD ^a
Pain	30–79	30–97	21–77	14–78	11–83
Breathlessness	20–88	16–77	56–98	18–88	11–82
Insomnia	26–77	3–67	15–77	36–48	1–83
Fatigue	52–86	23–100	32–96	42–82	13–100
Anorexia	49	76–95	64–67		38–64
Nausea or vomiting	58	2–78	4	2–48	8–52
Depression	4.5–64	4–80	17–77	6–59	2–61
Anxiety	14–45	3–74	23–53	2–49	7–52

Moderate to severe depression: **1 in 6**

Moderate to severe anxiety: **1 in 2**

Symptoms Are Often Undertreated



Symptom-Based Management

1. A wide range of symptoms co-occur in patients with DC, and addressing these symptoms is a key component of high-quality cirrhosis care.
2. For patients with DC, following general palliative care principles, we recommend systematically evaluating the presence and severity of a wide range of symptoms and addressing the symptoms most important to patients.
3. Often, the first approach to symptom management may be nonpharmacological, such as behavioral intervention, physical therapy, or other modalities that address multiple symptoms.
4. Underlying causes of symptoms should be identified and managed first.
5. Symptom management should consider best practices, disease stage, and patient goals and preferences.
6. Evaluation and management of symptoms should be interdisciplinary, when possible, including nursing, social work, and chaplaincy.

Pain

Abdominal Distension

Dyspnea

Hepatic Encephalopathy

Muscle Cramps

Sleep Disturbances

Fatigue

Pruritus

Sexual Dysfunction

Depression/Anxiety

Nausea/Vomiting

Symptom-Based Management

Nonpharmacological options

Hot/cold

Physical therapy

Mindfulness/meditation

Other behavioral pain self-management strategies (e.g., cognitive behavioral therapy)

Acupuncture (caution if platelets <50,000)

Other complementary options based on preferences (e.g., transcutaneous nerve stimulation)

Pharmacological options

Topical/injection treatments

Lidocaine patches

Capsaicin cream or patch

Topical nonsteroidal anti-inflammatory medications (e.g., diclofenac sodium 1% gel)

Injections by pain specialists (e.g., osteoarthritis of knee)

Systemic therapies

APAP 500 mg q6h for a maximum of 2 g/d is safe in most patients with.

Gabapentin 300 mg daily (starting dose) or pregabalin 50 mg b.i.d. (starting dose)^a (for neuropathic pain)

Fentanyl patch 12- μ g starting dose (typically not recommended as the initial agent; avoid in patients with sarcopenia/cachexia or fever)

Hydromorphone 1-mg q6h prn starting dose

Oxycodone 2.5-mg p.o q6-8h prn starting dose

Symptom-Based Management

Pain

Abdominal Distension

Dyspnea

Hepatic Encephalopathy

Muscle Cramps

Sleep Disturbances

Fatigue

Pruritus

Sexual Dysfunction

Depression/Anxiety

Nausea/Vomiting

Symptom	<u>Nonpharmacotherapies</u>	<u>Pharmacotherapies</u>
Dyspnea	<ul style="list-style-type: none"> • Manage reversible causes (e.g., volume overload, asthma, sleep apnea) • Bedside fans • Supplemental oxygen therapy • Mindfulness, meditation, guided imagery • Paracentesis • Thoracentesis • Placement of drains (usually in the setting of hospice care) 	<ul style="list-style-type: none"> • Opioids can be used cautiously in select cases, typically at the end of life (example: starting dose i.v. hydromorphone 0.2 mg every 3 h as needed, titrated to symptom relief) • Anxiolytics can be considered for dyspnea-associated anxiety (typically at the end of life when focus of care is comfort)
Muscle cramps	<ul style="list-style-type: none"> • Correct electrolytes 	<ul style="list-style-type: none"> • Taurine (2–3 g daily) • Vitamin E (300 mg three times a day) • Baclofen (5–10 mg three times a day)
Pruritis	<ul style="list-style-type: none"> • Moisturizing creams • Avoid hot baths and harsh soaps and detergents • Use loose-fitting clothing • Cool humidified air 	<ul style="list-style-type: none"> • Cholestyramine (4 g/d, titrated to 16 g/d if needed) • Sertraline (25 mg/d, titrated to 75–100 mg if needed) • RIF and naltrexone may improve pruritus, but their use is limited in palliative treatment of patients with DC. • Antihistamines (e.g., diphenhydramine and hydroxyzine) may help with pruritis-associated sleep disturbance given their sedating properties
Nausea and vomiting	<ul style="list-style-type: none"> • Correct electrolytes • Evaluate and treat adrenal insufficiency • Manage constipation • Review medications and eliminate potential triggers (e.g., lactulose, opioids) • Ginger • Mindfulness, relaxation • Acupuncture (use caution if platelets <50,000) 	<ul style="list-style-type: none"> • Antacids (if contributing reflux) • Ondansetron, up to 8 mg/d is preferred • Metoclopramide up to 60 mg/d (very preliminary safety data; potential adverse reactions) • May consider alternatives (e.g., prochlorperazine, haloperidol) depending on goals of care

Symptom-Based Management

Pain

Abdominal Distension

Dyspnea

Hepatic Encephalopathy

Muscle Cramps

Sleep Disturbances

Fatigue

Pruritus

Sexual Dysfunction

Depression/Anxiety

Nausea/Vomiting

Table: Summary of Side Effects, Cautions for Pharmacotherapies

Medication	Side effects, cautions
<i>Nociceptive pain</i>	
acetaminophen	Generally safe at low dose (2 gram daily maximum), can cause hepatic failure at high dose
Topical NSAIDs	Not tested in patients with cirrhosis (note that systemic NSAIDs are generally avoided in patients with cirrhosis)
Lidocaine patch	Site reactions (erythema), petechia, edema, pruritus, nausea, vomiting
Capsaicin cream	Site reactions (burning, pain, erythema), limb pain, hypertension
Opioids	HE, habit forming, respiratory depression, constipation/obstipation, overdose; preferred are oxycodone and hydromorphone
<i>Neuropathic pain</i>	
Gabapentinoids	Ataxia, sedation, myoclonus/asterixis, dose adjust in renal impairment, withdrawal syndrome, possible increased viral infections
SNRIs	Discontinuation syndrome, nausea, vomiting, sexual dysfunction
Tricyclic antidepressant medications	Anticholinergic, orthostasis, drowsiness, weight gain, sexual dysfunction
<i>Muscle cramps</i>	
Baclofen	HE, confusion, dizziness, sedation, nausea, vomiting, rare neurotoxicity in patients with renal failure, discontinuation syndrome
Zinc	Gastric irritation, rare neurological side effects
Methocarbamol	Hypotension, bradycardia, dyspepsia, pruritis, confusion, ataxia, HE, headache, sedation, changes in taste, seizure, vertigo, leukopenia, jaundice, changes in vision (dose reduced in cirrhosis)
Orphenadrine	Palpitations, tachycardia, confusion, sedation, pruritis, constipation, nausea, vomiting, tremor, urinary retention, blurred vision, central nervous system depression
L-carnitine	Side effects common with intravenous formulation; oral formulation generally tolerated well at normal doses

Symptom-Based Management

Abdominal Distension

1. Abdominal drains may be an alternative to serial LVP for patients with refractory ascites who are transplant and TIPS ineligible and whose goals are comfort focused. However, more comparative effectiveness research is needed before recommending this approach.

Hepatic Encephalopathy

1. Evaluating reversible causes and addressing HE can benefit both patient and caregiver quality of life.
2. Onset of encephalopathy can be an opportunity to provide education, elicit preferences, and discuss the overall trajectory of LD with a focus on ACP.
3. Approaches to the treatment of encephalopathy may depart from standard care at the end of life to align with patient goals and values.

Future Research, Clinical and Policy Implications

Primary Palliative Care Education

- Hepatology workforce training (core primary palliative care competencies)
- Bidirectional hepatology-palliative care education
- Palliative care training for social workers, psychologists, psychiatrists

Culture Change

- Addressing misperceptions of palliative care with patients and caregivers
- Addressing misperceptions of palliative care among clinicians
- Formal collaboration between palliative care and hepatology societies

Clinical Innovation

- Routine symptom assessment and management
- Co-rounding inpatient models and co-located outpatient clinics
- Automated triggers for specialty palliative care consultations

Health Policy Advocacy

- Advocacy to payers and hospice agencies
- Developing reimbursement infrastructure around palliative hepatology
- Incorporating measures of palliative care into cirrhosis quality metrics

Summary

- Decompensated cirrhosis is a **serious illness**; our challenges are to improve mortality, improve QOL, and support caregivers.
- **Palliative care** is an approach to caring for individuals with serious illness and their caregivers that prioritizes QOL. It can be delivered at any stage of serious illness.
 - Not same as hospice; can be delivered by primary or specialty providers
- Significant gaps in advance care planning, physical/psychosocial symptom management, and caregiver support exist for decompensated cirrhosis
- Communication, cross-education, and collaboration between hepatology, primary care, palliative care, and other disciplines is necessary to bridge gaps.

An aerial photograph of a coastal town, likely in California, featuring a large golf course with numerous palm trees in the foreground. The town is built on a hillside overlooking the ocean, with many houses and buildings visible. The image is overlaid with a semi-transparent blue filter.

Extra Slides

Review of Evidence for PC in Decompensated Cirrhosis

Author, year	Setting and population	Intervention	Comparator arm (study design)	Outcomes	Results	Palliative care domain addressed
Baumann et al. 2015 ^[54]	Outpatients being evaluated for LT	One-time nurse practitioner and board-certified PC physician performing comprehensive physical and psychological symptom assessment; ACP	None (pre-/post-single-arm quality improvement study)	Physical and psychological symptom burden; ACP	Improved pruritus, fatigue, well-being, appetite; decreased depression; increased ACP	1, 2, 3, 8
Kimbell et al. 2018 ^[57]	Outpatients with DC	Nurse specialists assisted in care coordination, illness education, financial and psychosocial support, and ACP and provided a summary of this discussion to the patient's primary care physician and hepatologist	None (single-arm feasibility study)	HRQoL; perceived care coordination, coping, anticipatory planning (qualitative)	Improved HRQoL and secondary outcomes	1, 4, 8
Lamba et al. 2012 ^[55]	Surgical ICU admission for patients pre-LT and post-LT	Two-part communication-based intervention involving palliative care team (APRN, family support counseling, chaplain): initial physical and psychological symptom assessment with ACP, followed by interdisciplinary family meeting within 72 h	None (prestudy/poststudy design)	Length of stay in ICU, mortality, goals of care consensus (qualitative)	Decreased ICU length of stay, better consensus in goals of care, lower receipt of life-sustaining treatment, and earlier provision of comfort-focused care; no difference in mortality	7, 8
Shinall et al. 2019 ^[56]	Inpatients with DC	Board-certified PC physician or nurse practitioner, during which patients were provided with an informational packet containing education on LD and PC	Control group of inpatients with DC receiving usual care (RCT)	Time until first readmission; days alive outside the hospital, referral to hospice care, death, readmissions, patient quality of life, depression, anxiety, and quality of EoLC over 6 months	Increased time to readmission; no change in other outcomes; poor enrollment	1, 3