

Decompensated cirrhosis and limited care resources: Whom to transfer to ITU?

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UEG Week Berlin 2025

Presentation

Hepatobiliary

October 7, 2025

The speaker presented a framework for ICU triage decisions in decompensated cirrhosis and ACLF patients, emphasizing the CLIF-C ACLF score as the best prognostic tool and transplant candidacy as a key priority modifier.

KEY POINTS

- The CLIF-C ACLF score is the best tool for ICU triage, superior to MELD or Child-Pugh; the speaker stated patients with scores of 50-60 points have 28-day mortality of 40-50%, and those over 70 have minimal survival.
- Transplant-eligible patients should receive priority for ICU admission because ICU can serve as bridge support to transplantation.
- In-hospital mortality is high: the speaker reported approximately 25-30% for patients with variceal bleeding or hepatic encephalopathy, and around 50% for hepatorenal syndrome or spontaneous bacterial peritonitis.
- A traffic-light triage system categorizes patients as green (ACLF grade 1-2, single organ failure, reversible problem, or active transplant listing), yellow (ACLF grade 2-3 requiring time-limited trials with re-evaluation every 2-3 days), or red (ACLF grade 3 or very high scores, potentially futile).
- Delays in ICU transfer worsen outcomes; the speaker stated in-hospital survival drops from approximately 25% with no delay to around 40% mortality with 24-hour delay.
- Social support, frailty, and functional status are important prognostic factors; the speaker recommended evaluating sarcopenia and frailty at each hospital admission rather than waiting for deterioration.

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