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Summary

ACLF: When to be concerned?

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Colorectal | Hepatobiliary | Pancreas

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The speaker reviewed the evolution in understanding acute-on-chronic liver failure (ACLF) and acute decompensation in cirrhosis, emphasizing the role of the CANONIC and PREDICT studies in defining disease courses, triggers, and treatment strategies including early intervention, NSBBs, TIPS, and transplant prioritization.

KEY POINTS

- The PREDICT study identified three clinical courses of acute decompensation with mortality rates of approximately 10%, 35%, and 67% per year, and found that bacterial infection and severe alcoholic hepatitis are the predominant triggers causing up to 97% of ACLF cases, with early identification and treatment potentially reducing 90-day mortality by about 25%.
- The CANONIC study established the ACLF score based on six organ systems, which showed significantly higher discriminative ability than MELD and Child-Pugh scores, and defined ACLF by the presence of decompensated cirrhosis, organ failure, and systemic inflammation.
- The speaker stated that non-selective beta blockers significantly reduced HVPG, decompensation rate, and mortality in patients with compensated cirrhosis and clinically significant portal hypertension, and the Baveno consensus recommends NSBB prophylaxis to prevent all forms of decompensation.
- Early pre-emptive TIPS within 72 hours is indicated in high-risk variceal bleeding patients (Child-Pugh >7 with active bleeding or HVPG >20mmHg), and the speaker reported that TIPS significantly reduced rebleeding and mortality rates.
- For acute kidney injury in ACLF, the speaker noted that a new International Ascites Club consensus eliminated the 48-hour albumin requirement before terlipressin, though a publication by Cristina Ripoll et al found nearly 50% of patients respond to albumin after 48 hours, and a position letter by Paolo Angeli recommends continuing albumin first.

– The speaker emphasized that the MELD score substantially underestimates mortality in higher-grade ACLF patients, and EASL guidelines recommend prioritizing these patients on transplant waiting lists, while patients with ACLF scores over 70 points at 3-7 days after intensive care initiation have nearly 0% 28-day survival without transplantation and should be considered for palliative care.

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