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Summary

Panel discussion: Decision-making in acute liver failure: From expectant management to emergency transplant

Postgraduate Teaching Programme Barcelona 2026 | Presentation

Surgery | Hepatobiliary

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Panel discussion on acute liver failure management emphasizes early transfer to transplant centers once coagulation failure develops, plasma exchange as a bridge to transplant, and the critical role of empirical corticosteroids when autoimmune hepatitis is suspected despite risk in drug-induced liver injury.

KEY POINTS

- Patients with acute liver failure are often transferred too late; the speaker stated that once coagulation failure is present patients should be transferred to transplant centers, and there is no internationally recognized protocol for timely referral.
- Neurological improvement is more relevant than blood test improvement for decision-making, and plasma exchange can serve as a bridge to transplant to gain time though the patient discussed was ultimately transplanted.
- The speaker reported that corticosteroids can be lifesaving in autoimmune hepatitis and should not be delayed for histology, but emphasized that corticosteroids in drug-induced liver injury can be really harmful with a new study on this forthcoming.
- NAC is used in virtually all patients despite less robust data for severe encephalopathy because it potentially does no harm, and the speaker stated their center lost 3 to 4 patients from missed herpes diagnosis highlighting the importance of early antiviral therapy.
- Early transfer allows assessment of the patient's social and psychological situation before severe encephalopathy develops, which is particularly important in severe paracetamol intoxication cases.
- Post-transplant, acute liver failure patients are considered at higher risk of kidney and brain failure; one speaker's center introduces tacrolimus on the fifth day with lower doses in these patients.

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