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Recurrent Variceal Bleeds: The Ethics of When Enough is Enough

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Disclosures

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Advisory Board: Salix, Clinical Area – IBS
Objectives

- List options (e.g., meds, procedures, other interventions) *(only use generic names; no brand names)*
- Group to discuss the various options and when one should be considered over another
- Discuss important issues such as compliance, adverse events, ethical dilemmas and complications to consider
A Day in the Life of the GI APP With GIB Pt.
Case Study # 1

37 yr old male with Etoh Cirrhosis-actively drinking, encephalopathic, failed treatment eval at 2 centers, non adherent, ascites and homeless

8th admission in 9 months for Cirrhosis events now admitted with H/H of 4.7gms/18.5, platelets 38k- due to brisk variceal bleed. Massive Transfusion Protocol (MTP) enacted

6 units of PRBC, 2 units of FFP, 2 units of Cryo. Then 2 more units PRBC with EGD

Grade 4 varices with red wales sign banded x4. hgb stabilized 7.6gms, Platelets 56k, INR 2.4, T.B 2.8, Creatinine 1.9, NA 134

48 hours later Observed 700cc hematemesis; intubated for airway protection
What Type of GIB Is This?

- Acute variceal bleeding – admission to 120 hours or day 5
- Variceal rebleeding- bleeding that occurs >5 days after first hemorrhage, provided that hemostasis was initially achieved.
- Clinically significant – 2 units or more of PRBC in 24 hours of time zero with SBP<100 mmHG, change in orthostasis > 20 mmHg or HR >100 bpm
- Failed response to endoscopic variceal ligation (EVL) is recurrent bleeding despite at least 1 treatment EVL
Three Choices

1. What initial life saving measures to you pursue? Should you?

Repeat EGD
Consult IR for early TIPS
Consult palliative care/hospice
Case Study # 1

- Early TIPS vs. standard therapy with EVL + vasoconstrictors
- Population – HR pts in Child score B & C (score 10-13)
- Study – Retrospective analysis 45 pt in early TIPS and 30pts in standard
- Results – 50% of standard group failed in 13 months follow up timeframe and only 7% in early TIPS group
- Mortality 33% died in standard and 13% in early TIPS
2. Do you re-enact MTP?

Yes

No
Follow the Arrows...

Death spiral of over-resuscitated variceal hemorrhage

- Over-resuscitation:
  - Excess crystalloid
  - Excess FFP in efforts to “normalize” INR
  - Massive transfusion activation
  - Targeting “normal” Bp

Variceal Bleed

Hypocalcemia
Hypothermia

Increasing CVP directly increases the pressure within varices

Dilution of platelets and fibrinogen

The Internet Book of Critical Care, by @PulmCrit
How Many Cooks in the Kitchen?

3. Who is involved with the decision?

- Ethics Committee
- Risk Management
- Multidisciplinary team of ICU/GI/Hepatologist/IR
4. What if Blood Bank is low – especially given Pandemic
5. If EGD is done again, where is it done?

• EGD deferred
• Bedside in ICU
• GI Lab
• Operating Room
Case Study # 2

57 yr old uninsured cachectic female with decompensated cirrhosis 2/2 NASH Dx 10 yrs ago, UGIB 2/2 esophageal varices x2 (last paracentesis yesterday with removal of 1.2 L of fluid), CAD s/p stent placement, HFpEF, DMT2 admitted for jaundice, recurrent hematemesis and melena.

MELD score: 15 Child-Pugh score: 12 (Child Class C)

Hgb 6.3g on admission s/p 1 unit of PRBC repeat Hgb 7.4gm
Na 131,BUN 42,Cr 1.20,T bili 5.0,Albumin 3.7,PT 16.9,INR 1.3

EGD revealed grade 2 esophageal varices, adherent clot over IGV-1 varix with associated antral erythema which starts to actively bleed during procedure. Linton-Nachlas tube placed until advanced endoscopist is available.
Gastric Varices

Type 1 GOV  most common 70%
Type 2 GOV 20%

Highest risk of bleed Type 1 IGV followed by Type 2 GOV

Risk of Bleed: PH<size, tension, red wale signs

Three Choices

1. What initial life saving measures do you pursue? Should you?

- Repeat EGD
- Consult IR again!
- Consult palliative care/hospice
Four Pillars of Medical Ethics

• Autonomy
• Beneficence
• Nonmaleficence
• Justice
2. Will the next intervention provide any obvious ethical issue involving beneficence?
3. Family wants “everything done”. When do you approach quality of life, code status and withdrawal of care as clinical status has changed.
Now What?

4. Family has decided to remove her from the liver transplant list but does not want palliative/hospice care yet. Does this impact future treatment measures?
Palliative Care for Patients With ESLD

- Median survival/prognosis
- Palliative vs Hospice
- Challenges
- Timing the Talk

Case Study # 3

21 yr old female with PSC-UC, Child B known to have grade II varices, banded x2. She missed surveillance EGD due to fear of coming in during setting of Pandemic. Is on transplant list, awaiting match. Meld - Na 26, ascites stable with oral diuretic, no overt encephalopathy, but MELD-Na is high. Developed NOROVIRUS with profuse N/V then witnessed 600ml episode of hematemesis which dropped her to H/H to 5.7/21.3, Platelets 52, INR 2.1,

Total 4 units PRBCs & 1 cryoprecipitate given

EGD done banded 4 columns of grade 3 varices with stigmata of bleeding x3

This is her 4th Variceal Bleed
Choices...Choices

1. What procedure could be considered?
2. What preliminary studies should be done first?
3. What are consequences of intervention should be considered?
Silver Lining….

4. What is desired outcome once contact is made with liver transplant center?
It's not hard to make decisions when you know what your values are.

Roy E. Disney
Case Study # 4

47 yr old male with PMHx of alcoholic liver disease, HTN, esophageal varices s/p banding x3 2 weeks ago, MELD 36, CP Class C, he is uninsured and presents from PCP clinic after found to have hemoglobin of 2.5gms with new onset black stools & dark vomiting 3 days ago however today he had 300 cc of BRB. Reports bilateral lower extremity swelling, and increasingly distended abdomen with moderate pain throughout the abdomen, worse with laying on his back.

In the ED patient was found to have hemoglobin 3.7, platelets 60s, INR 2.1, creatinine. Patient was started on octreotide and PPI drips, 3 units of PRBCs ordered. US showing cirrhosis of liver with multiple liver masses concerning for malignancy, moderate large volume ascites.

PPI & Octreotide gtt started in ER and Vitamin K and FFP given.

EGD planned after resuscitation.
Clinical Cues

1. What are the reasons for the resuscitative goals and any need for additional medications?
Endoscopy done showing 2 columns of grade 3 varices which were banded.

Pt develops Acute kidney injury is likely multifactorial in etiology and due to increased intraabdominal pressure from massive ascites compromising renal blood flow, bilirubin induced tubular injury, hemodynamics and possible hepatorenal syndrome.

– His SCr level is up to 5mg/dL from previous value of 1.5 mg/dL
– He does not make much urine and is clinically volume expanded
– Blood pressure is borderline low
2. What steps are taken to manage the AKI? What concerns are in your differential?
3. How does the worsening AKI impact your next steps in the work up of the liver lesions? What options and risks are you facing?
4. Triple phase CT was done finding compatible with multifocal 8 cm HCC with tumor thrombus -AFP = 864. Renal function worsening. What discussions are needed and who should be involved in care?
5. Pt not accepted at LTC as does not meet criteria however HD was started and social work has just notified you that pt is undocumented thus LTC is not an option. He has a recurrent episode of 200 ml of hematemesis. What are the next steps in your management?
Comfort, Peace and Rest

Spoke to Niece over the phone, pt is in poor health as he was intubated this morning and that GI states that pt is no longer a good transplant candidate and that they recommend hospice care. Family is aware of options for hospice inpt vs home hospice. Pt's sister will discuss w/the rest of family and hopes to make a decision by tomorrow.
Moral of the Story...

It's not hard to make decisions when you know what your values are.

Roy E. Disney
Thank you