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Optimizing Care of the Hospitalized Patient With Overt Hepatic Encephalopathy

Announcer:
Welcome to CE on ReachMD. This activity is provided by TotalCME and is part of our MinuteCE curriculum.

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Dr. Reau:
This is CE on ReachMD, and I'm Dr. Nancy Reau. How do we optimize care of a hospitalized patient with overt hepatic encephalopathy?

Well, the first thing is, it's really important to be in the hospital, especially with that first episode, but any episode of encephalopathy that increases the risk of a patient having a complication from something that was missed. So remember, triggers of encephalopathy include infections, electrolyte abnormalities, medications, and these are all best managed in the hospital.

And then if the patient is more affected, there's risk of getting aspiration or just titrating the medication safely. So a confused patient is best managed in the hospital.

But then when a person is getting ready to be discharged, that transition is equally important. So inpatient management requires stabilization of the disease, excluding alternative explanations like medications, infections, electrolyte abnormalities, another reason for confusion, like cerebral bleed or another delirium episode.

And then once your patient is stable, you're going to use whatever needed to stabilize that patient to continue in the outpatient setting. So if this was a first episode of encephalopathy and your patient was nicely managed with lactulose alone, your patient's going to need to go home on lactulose. If it was the second episode of encephalopathy or more, or your patient did not get management with lactulose alone and also required the addition of rifaximin, then this person needs to be sent home on both lactulose and rifaximin.

And discharge planning is vital. Here, you need to make sure that you get prior authorization of your rifaximin, or at least hand that off to the outpatient team so that they're working on this so that when the patient goes home, they have access to the medicine that prevents another episode of encephalopathy.

You want to make sure you label things correctly, putting that ICD-10 code in for encephalopathy, so that there's no misunderstanding at the pharmacy, thinking that your rifaximin was for traveler's diarrhea or for irritable bowel syndrome. And then making sure you write on there the indication for the rifaximin is overt hepatic encephalopathy. Again, making sure that the indication matches the ICD-10 code. That's going to have a much higher association with your patient getting the medicine for the period of time that your patient needs it, which is long term, not for a 2-week or a short period of time.

And then making sure you touch base with this individual. You're going home from something that was really, really scary, whether it was caused by an infection or whether it was just a progression of your liver disease, which means you need to have a quality conversation about what this means for prognosis. Are we going to have to talk about transplant? But also, are you getting seen in the clinic quickly?

You should be seeing this patient within 1 to 2 weeks, because these are individuals that are at very high risk for another episode and rehospitalization.

And one of the most important things is that transition, either through the case manager or from the inpatient to outpatient team, which often requires a phone call. Did you get your medicines? Do you understand why you're taking them? Are you taking them? It's not good enough to have them all if you're not actually taking the medications.

And involving the care team, which often includes things like your other providers, like your primary care provider, maybe a gastroenterologist or a hepatologist that wasn't taking care of the patient as an inpatient, but also the family, the people that are going to be helping that individual navigate something that is going to affect their quality of life. Lots of times, especially with the first episode, we're telling someone that this is going to impact their ability to be employed, their ability to drive. And this has to be a family affair.

If I tell you not to drive, but no one tells your family, and you go home, you get into a car accident, or there's something that occurs that's a bad—liability aside—that's a bad situation. And a family realizes that they have to help, even if it's making sure that Uber rides or a resource is available to this individual and emphasizing why they can't drive. Remember, someone who's confused may not have all those resources to remember that this is a bad idea. So those touchpoints to say, yeah, this is not a good idea. Let's figure out another way to make sure that you can navigate and have some degree of autonomy that is done safely.

So if you take one thing away, prevent relapse, rehospitalization. I'm glad I was able to share this information with you.

Thank you for listening.

Announcer:
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