CASE RECOMMENDATION FORM

ECHO Session Date: 8/21/2024

Presenter Credentials: MD

Thank you for presenting your patient at ECHO Idaho – Liver Disease & Viral Hepatitis session.

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Case Summary:

55-year-old, incarcerated male with a history of alcoholic cirrhosis, presumed decompensated cirrhosis, and hypertension controlled with HCTZ 12.5 mg and lisinopril 4 mg. Negative hep C antibody screen and negative HIV screen in 2023. Significant alcohol use history of 20+ years with hospitalizations, but has had at least two years of alcohol abstinence. Presumed he's on Lactulose and rifaximin for preventing hepatic encephalopathy. No electrolyte abnormalities. No history of varices. Last abdominal ultrasound in June 2023. Mild heterogeneous and increased echogenicity of the liver may be from steatosis. Other hepatocellular disease is not excluded. No large focal lesions seen. No abnormal intrahepatic biliary dilatation. Hepatoportal flow noted at the portal vein. Liver length is 15.4 cm. Common bile duct measures 3.7 mm maximum diameter, within normal limits. Has not had ROI for liver history. No INR in chart. BMI is 36.91. Labs: Platelets 249, Total Prot 7.4, Albumin 4.6, AST 17, ALT 18, T. Bili 0.4, APRI 0.171, FIB-4 0.89

Central Question:

What is the appropriate screening for him in terms of hepatocellular carcinoma, esophageal, esophageal varices? And are there recommendations for best forms of treatment for his high blood pressure given the information? If we are treating him as a patient that has alcoholic cirrhosis, are there best practices in terms of managing blood pressure for most effective drug classes? Is the diagnosis of decompensated cirrhosis consistent with his clinical picture? If this diagnosis is not fully complete, what things should we do otherwise? Get a transient elastography? Other labs? For patients with non-viral hepatitis cirrhosis, are the FIB-4 and APRI scores, like FibroSURE, not validated for assessing liver fibrosis?

Recommendations Part 2

Hepatitis Serologies:

- Obtain Hepatitis B surface antibody and surface antigen tests, as well as total Hepatitis B antibody levels.
- Check for Hepatitis A IgG, as these values are not listed but recommended.

Liver Assessment:

- With normal platelet count, AST, ALT, and alkaline phosphatase, consider questioning the diagnosis of cirrhosis.
- The FIB-4 score of 0.89 suggests a low likelihood of severe hepatic fibrosis (F3-F4), further questioning cirrhosis.
- Consider additional non-invasive testing, such as a Fibroscan, to confirm the absence of advanced fibrosis.

Ultrasound Findings:

- Review liver ultrasound showing normal hepatic blood flow and a normal liver length of 15.4 cm, which is atypical for cirrhosis.
- Check for spleen size, as it is not mentioned in the current findings, which could help rule out cirrhosis.

Further Testing:

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- Avoid liver biopsy; prioritize another non-invasive test (e.g., Fibroscan) due to its cost-effectiveness compared to long-term screening with ultrasound and alpha-fetoprotein (AFP).

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Recommendations: Part 1

- Lab Considerations:
  - Current labs look reassuring. Consider regular monitoring of his basic labs, including his repeat CBC, CMP, INR, and AFP.
- Hypertension Management:
  - Continue current antihypertensive medications (HCTZ and lisinopril) as blood pressure is well-controlled.
  - Monitor for any potential renal dysfunction or electrolyte imbalances due to antihypertensive therapy.
  - Consult a hepatologist or GI specialist to reassess the appropriateness of antihypertensive therapy given the history of cirrhosis.

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Consider presenting follow-up for this patient case or any other patient cases at a future ECHO session.

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