Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/Treatment-of-Hepatic-Encephalopathy-Primary-vs-Secondary-Prophylaxis/39791/

Released: 12/11/2025
Valid until: 12/11/2026
Time needed to complete: 55m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Treatment of Hepatic Encephalopathy: Primary vs Secondary Prophylaxis

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

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Jesudian:
This is CE on ReachMD, and I'm Dr. Arun Jesudian. Here with me today is Dr. Nancy Reau.

Nancy, talk to us about the treatment of hepatic encephalopathy.

Dr. Reau:
Thank you so much, Arun. So in a person who's sicker, so often that first episode of confusion where they're in the emergency room or admitted to the hospital, we talk about a 4-pronged approach to clinical practice. That means you have to address this altered consciousness. If your patient's in a coma, they need to have aspiration precautions, often intubated, and you're going to exclude overlapping things—make sure you did not miss a cerebral event, or a medication, or toxicology if a person might have a risk for alternative medications or substance abuse. And then you're going to start them on therapy. It's really important to know that response to treatment confirms encephalopathy.

And you're going to do this all at the same time, as well as excluding exacerbating things like electrolyte disturbances, hypoglycemia, hyponatremia, renal dysfunction. And you're going to not do that in a stepwise approach, but kind of blanket all of those things at the same time and see what sticks.

In a person who you've now narrowed this down to encephalopathy, pharmacotherapy is really important. And first-line treatment for all of our patients is going to be lactulose—not the most pleasant, but this unabsorbed carbohydrate causes diarrhea and bloating but also acidifies the colon so that you prevent the transition from ammonia to ammonium, and then it's not going to be absorbed as well. Because it's also cathartic. You're going to be excreting a bunch of other toxins, and that should work.

Now, in our patients who have had more than one episode of encephalopathy, or where lactulose alone is not clearing the patient adequately, we add a nonabsorbed antibiotic, rifaximin. And whatever worked is what you want to continue. So secondary prophylaxis is really important. Send the patient home on what induced remission of their encephalopathy. If that was lactulose alone, great. If it was a second episode of encephalopathy, it's going to be combination therapy with lactulose and rifaximin.

Now, one of the other things that people will talk about is preventative therapy. We do not have pharmacotherapy to prevent the first episode of encephalopathy, but there are a lot of other things you can do: maximize nutrition, maximize your muscle mass, look at those

medications that are sedating or polypharmacy. These are all going to be problems that increase the risk of confusion and probably unmask more subtle encephalopathy in a person who's struggling between that minimal covert-to-overt transition.

Dr. Jesudian:
Such important information. And I think in your patients with cirrhosis who have not yet had an episode of overt hepatic encephalopathy, in addition to everything you mentioned, it's important for us to just be vigilant about looking for signs and symptoms of even subtle hepatic encephalopathy. And certainly, once they've had that first episode, or any recurrent episodes, we want to make sure that we have them on the best therapies available, usually lactulose and rifaximin in combination, which we know can prevent recurrent episodes and hospitalization.

And how do you talk to your patients about those therapies, just so they're aware of how to take them and how they work?

Dr. Reau:
Yeah, that's a point that cannot be underemphasized. When your patient's going home from an episode of confusion, that patient's going to be overwhelmed, especially if it was the first time. And so one of the most important things is to get them back into clinic or to have that transition phone call to make sure you review what medicines they're on and why they're on them. A lot of patients really just don't fill their prescriptions or are a little confused as to why they're taking things, especially if it's something that has side effects like lactulose or if it's an antibiotic when they don't think that they had an infection.

And so also engaging the team that's going to help them. So even if the patient's a little overwhelmed, if you at least are talking to the group that's taking them home and going to be checking on them, emphasizing that these medicines are going to prevent another episode that was so scary that led to this hospitalization. And then communicating with all the other providers that take care of them—not to say that a primary care doctor or another clinician is going to stop your therapy, but really emphasizing the importance and being sure that the patient's adherent, because patients do have their care extended over multiple providers, and you want to make sure you're all on the same page.

Dr. Jesudian:
Thank you. So if you take one thing away, prevent overt episodes and hospitalization. And that's knowledge you can put into practice with your next patient.

Thanks so much, and we'll see you next time.

Announcer:
You have been listening to CE on ReachMD. This activity is provided by TotalCME and is part of our MinuteCE curriculum.

To receive your free CE credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.