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/collaboration-and-management-of-he-establishing-foundation-for-successful-outcomes/24185/

Released: 03/22/2024
Valid until: 03/22/2025
Time needed to complete: 1h 06m

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

Collaboration and Management of HE: Establishing Foundation for Successful Outcomes

Announcer:
Welcome to CME on ReachMD. This episode 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. Rahimi:
Hi everyone, my name is Robert Rahimi. I'm a Transplant Hematologist at Baylor University Medical Center in Dallas. And we're here to talk about Collaboration and Management of Hepatic Encephalopathy: Establishing Foundation for Successful Outcomes. And I'm here with Arun Jesudian. And I'm honored to be here to have this roundtable discussion.

Dr. Jesudian:
Thanks, Bob. My name is Arun Jesudian, and I'm also a Transplant Hepatologist. I'm at Weill Cornell Medicine, New York Presbyterian Hospital in New York City.

And I'd like to start us off by giving the audience an understanding of the multidisciplinary team and how important that is in taking care of these complex patients with hepatic encephalopathy. So, Bob, could you give us an overview of some of those team members and what role they play in taking care of HE patients?

Dr. Rahimi:
Yeah, that's a great segue. So, as you know, hepatic encephalopathy is a complex disease, confusion in the brain due to patients with chronic liver disease or end-stage liver disease in cirrhosis and portal hypertension. And these patients when they get confused, all the team members need to be involved. Us, like hepatologists, we rule out the different causes or precipitants. But the important part for other team members are like the dietician. As you know, patients with cirrhosis, they have a catabolic state, so they break down a lot of protein, they lose muscle mass. And muscle can be a sink for ammonia, a partial sink for ammonia, where if you have more muscle mass, you can absorb some of the ammonia and then excrete it through the kidneys, and obviously through the bowels with proper treatment like lactulose. However, these patients need, you know, 1.2 to 1.5 g/kg protein. And so, they become important to discuss that because it's really hard for these patients to eat a lot of protein.

As far as the pharmacists, as you know, some of these patients come in like in a coma. It's difficult to have lactulose as a therapy through their NG tube, so they get rectal lactulose. And they help with that. They help with some of those orders.

But as you probably would agree, that the nurses become probably one of the most important part of the team on these inpatients because they're going to have to give the these therapies or treatments like lactulose, you know, 3, 4, 6 times a day to have patients start with a few bowel movements, and titrate that medicine.

But that's just a brief background. Is there anything, Arun, that you can see, like let's say from social workers or home healthcare or any other part of the team that would be important?

Dr. Jesudian:

Yeah, absolutely. So, social workers and case managers become really important when we start planning for discharge, when a patient with hepatic encephalopathy is nearing the end of their hospitalization. And part of that has to do with the fact that we recognize this condition as being one of the major reasons that these patients get readmitted to the hospital, come back, oftentimes within a short period of time within 30, 60, 90 days. And so, planning for their discharge and making sure that they have what they need when they leave the hospital is really the best way to try and keep them out of the hospital and keep them healthy. So, social workers can help if they should need services at home, for example, if they need transportation services to and from appointments. Case managers or discharge planners can ensure that they have adequate follow-up, that they have access to the medications that you've prescribed for them to prevent some of these episodes of hepatic encephalopathy. So, that is a large part of taking care of patients in the hospital that focuses more on discharge and preventing readmissions.

And just to build off what you were saying about dieticians and protein intake and these patients' tendency to lose skeletal muscle mass, what also often happens in the hospital and sometimes after discharge is a rehabilitation, physical rehabilitation plan. So, in the hospital, these patients might be seen by physical therapists and occupational therapists to really increase their mobility to hopefully improve some of the frailty that we commonly see in these patients who have cirrhosis and are in this catabolic state and have been sick and in the hospital. And they might actually even need to go to a subacute rehab facility or somewhere that will bridge them to getting home in terms of their functional status. And that's why we really often try to mobilize these patients early during the hospitalization because we know that could be a barrier to their discharge, or to their ability to go home when we've treated their acute medical issues.

And, Bob, I wanted to ask, you know, these are ill patients, we oftentimes are evaluating them and listing them for transplant, some of them are not able to undergo a transplant. So, could you talk a little bit about, say, palliative care, end of life care in this population when we're not able to replace their liver, which is the root cause of their hepatic encephalopathy?

Dr. Rahimi:
Yeah, that's a great question. It's challenging, because as you know, it's very difficult. You know, we want to help everyone, we want to try to get patients better. But I think part of the Hippocratic Oath, you know, do no harm, if we can see it from the patient's perspective. Let's say we have a patient, I'm giving an example of someone who has metastatic hepatocellular carcinoma due to their cirrhosis, so it spread liver cancer all over. And they have portal hypertension, so they have recurrent hepatic encephalopathy. And, you know, the family members as well as the patient, they're suffering, right, they keep coming back into the hospital, you probably had a couple of these patients, you know, every couple of weeks, they can't keep out of the hospital with all these care teams that we have in place from an outpatient standpoint. So, if they continue to come to the hospital, we have a serious discussion with them, we talk to them as their hepatologist and say, look, what does the patient want? Do they really want to be comfortable, you know, be at home? We can get then kind of going back to your point of getting them services, we can get them hospital beds, we can talk to palliative care. We do actually consult them if patients are ready and family members are ready to undergo, you know, transition to comfort. And then we potentially get hospice involved. But that becomes important because then they're in their own home and they don't have to get readmitted multiple times. And it's a big deal for patients and family members to come in and say, 'Look, there's not much more we can do.' But that's a very fine line to discuss that with the family members. But they have to be ready. So, it's a challenging part of our jobs, I believe. But that's part of it to make sure that they can continue on to comfort care and not suffer.

But, Arun, I wanted to ask you, do you have anything in place before that? Like that's obviously the end stage, and if we don't need to get there, we obviously want to help all these patients. Is there continuity of care in the sense of once patients get discharged, do you see them back in clinic pretty quickly to kind of go over some of the medicines and talk about what HE is?

Dr. Jesudian:
Absolutely. It is difficult to tackle a lot of that education during the hospitalization and in a way that the patient can retain that information. So, it is important for them to have follow-up soon after the hospitalization in terms of our discharge planning, so in the first week or two. Oftentimes, that follow-up will be with one of our APPs, so a nurse practitioner or a physician assistant who works with us in the hepatology practice and they are used to taking care of these patients. And they are then able to educate the patient, their caregivers about what hepatic encephalopathy is, about how to take their medicines, about what to look out for. And they can see them usually, you know, in a more timely manner than the hepatologists. Our schedules are often very full and we're booking out several weeks or, you know, sometimes months in advance. But our APPs are so integral to how we take care of our very complex patients, particularly following hospitalizations.

Do you have a similar model? And do you employ any strategies to try and keep these patients out of the hospital?

Dr. Rahimi:
Yeah, we actually do the same thing you do. We have a readmission prevention hepatic encephalopathy clinic where one of our APPs is in charge of that. And the goal is after, like you said, after discharge, it becomes very challenging to go over everything, they retain

limited information. And so, they spend an hour in clinic to go over what cause is, what the prevention is, how to titrate their medicines, what things to look out for. So, I'm glad to see that we both do something similar to try to help our patients in the long run for hepatic encephalopathy and get admitted less frequently.

So, I think that's a good place to end. And it was a pleasure being on here with you to discuss these cases. I'm glad we had a lot of similarities. So, thank you all for joining and until next time.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, LLC. and is part of our MinuteCE curriculum.

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