Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/the-impacts-of-analgesics-in-patients-with-cirrhosis/18076/

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

The Impacts of Analgesics in Patients with Cirrhosis

Dr. Buch:
This is ReachMD *GI Insights*, and I'm Dr. Peter Buch. Joining us today to discuss the use of analgesics in cirrhosis is returning guest Dr. Naga Chalasani. Dr. Chalasani is the David W. Crabb Professor of Gastroenterology and Hepatology at Indiana University School of Medicine.

Welcome back to the program, Dr. Chalasani.

Dr. Chalasani:
Dr. Buch, I'm pleased to be back today.

Dr. Buch:
Looking forward to our discussion. To start us off, Dr. Chalasani, what should we know about acetaminophen use in patients with heavy alcohol consumption?

Dr. Chalasani:
People who drink any amounts of alcohol should be cautious when taking acetaminophen. The reason being heavy alcohol consumption induces an enzyme called cytochrome P450 2E1 and also depletes glutathione in the liver. Both of these would generate excessive amounts of toxic metabolite called NAPQI from acetaminophen that can cause liver injury. Therefore, people who consume heavy amounts of alcohol should not take excessive amounts of acetaminophen, which is no more than two grams in a 24-hour period.

Dr. Buch:
Thank you. And to examine this further, should we be concerned about long-term over 14-day use of acetaminophen in patients with cirrhosis?

Dr. Chalasani:
Good question. I would say long-term use of acetaminophen in people with cirrhosis should be okay as long as it is a limited dosage. I mean that to say less than two grams per day should be very safe relative to other types of analgesics that are available for patients with cirrhosis.

Dr. Buch:
And should we be modifying this based on the fact of there being compensated or decompensated cirrhosis?

Dr. Chalasani:
Two grams per day is safe even in people with decompensated cirrhosis, which in clinical practice largely you can characterize by somebody with ascites-required diuretics, just a rule of thumb for the audience. The two grams should be safe even in such people with decompensated cirrhosis. However, somebody who has compensated early cirrhosis, they can take up to four grams per day, up to 14 days, but long term regardless, I suggest that one should just try to limit to no more than four extra strength tablets of Tylenol in a 24-hour-period.

Dr. Buch:
Great. So let's now move on to another analgesic. Are there any safe NSAIDs for patients with cirrhosis?

Dr. Chalasani:
In people with early cirrhosis, Childs A without large esophageal varices or other portal hypertensive gastropathy, a short course of things like ibuprofen is reasonable. Everything comes down to risk versus benefit. If you have a compensated cirrhotic patient, broken

their ankle, you need a short course of nonsteroidals. If they are very compensated, I would be comfortable to give five days of ibuprofen, but somebody with decompensated ascites, I would be cautious with nonsteroidals.

Dr. Buch:
Great. And a further question for those in primary care listening to this recording, what would you advise for primary care providers out there who have cirrhotic patients who have not yet assessed their patients for varices?

Dr. Chalasani:
First of all though, if you have patients with cirrhosis who have not had an endoscopy to identify their varices status, just make it a general practice to get it done I think is standard of care; but somebody just got diagnosed with you haven't had a chance to send them to a gastroenterologist in such people, if possible I would try to avoid nonsteroidals. Once again, though, the nonsteroidals should not make varices bleed themselves. The variceal bleed is thought to be less to do with erosions of the varices. It has more to do with the pressure. It is the portal pressure. In other words, if somebody has severe reflux esophagitis, and also has large varices, the thinking is that the esophagitis doesn't cause the bleed. It is when the portal pressure goes up. Besides the varices, people with cirrhosis can have portal gastropathy. Nonsteroidals arguably can make it worse and can make them bleed, so it's not necessarily the variceal bleed, but it is the bleeding from portal gastropathy, which is severe congestion of a gastric mucosa in people with portal hypertension.

Dr. Buch:
And as a follow-up question to that, again directed to our primary care listeners, what is the accuracy of a CAT scan or an MRI in detecting esophageal varices?

Dr. Chalasani:
Largely not helpful. You will see radiologists comment on taking the esophagus para-esophageal collaterals or abdominal collaterals, but none of them really have high correlation with luminal gastroesophageal varices. So what you really want to know is varices in the distal third of the esophagus and proximal stomach that are bulging into the lumen, those aren't necessarily accurately identified in a cross-sectional imaging like MRI or a CT scan, so therefore, one needs to get an upper endoscopy, unfortunately.

Dr. Buch:
Thank you. So do you ever consider tramadol for cirrhotic patients?

Dr. Chalasani:
Yeah. I have several patients who are on maintenance tramadol for severe back pain that is just simply not relieved by acetaminophen. I use something like 50 milligrams twice daily. Once again it comes down to risk versus benefit. From a liver function standpoint, tramadol is safe, and I think there is plenty of data about that in the literature. Even I use that in people with advanced cirrhosis ascites. It can precipitate hepatic encephalopathy at higher doses, so I would try to use the maintenance dose. Just another word of caution is if you are prescribing tramadol to people with decompensated cirrhosis, make sure that they have adequate bowel movements. Otherwise, it can precipitate hepatic encephalopathy because of constipation and ammonia buildup.

Dr. Buch:
Thank you. So for those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Chalasani about the use of analgesics in cirrhosis.

So I'm going to crank it up a notch here. Dr. Chalasani, under what circumstances do you prescribe opioids to your outpatients who have compensated cirrhosis?

Dr. Chalasani:
Once again, I say this risk versus benefit. If a compensated cirrhotic breaks their humerus or a femur, I think a short course of opioids is reasonable. So it is your clinical assessment where you believe that things like a short course of acetaminophen or nonsteroidals are not going to work, I think it's a reasonable consideration. Once again, I would be cautious and not giving a long-term duration prescription. I would do a short seven-day course, perhaps, and I would just reiterate it is risk versus benefit though.

Dr. Buch:
Absolutely. So again, let's talk about that same question we just discussed, the treatment algorithm now for decompensated cirrhotic patients who need analgesia.

Dr. Chalasani:
Once again, just depends on how severe the pain, whether it is acute or chronic. If somebody has chronic back pain, severe arthritis in the lumbosacral spine and they need long-term analgesics, I traditionally don't go beyond acetaminophen in these people, and I would give up to two grams per day, but I will do other things, such as lidocaine patch or diclofenac gel. These are topical compounds, and I

think they can be useful. They may just give a 10 percent pain relief, but you just have to do multimodality or multiple things to put them together. Certainly, sending them to physical therapy, other types of things as well you need to consider.

So for chronic pain, chronic noncancer pain in decompensated cirrhotics, I strongly advise against opioids. I also advise against nonsteroidals. You're okay to use acetaminophen up to two grams per day. In terms of acute pain, if somebody needed a hip replacement or a broken joint, or the thing that we see frequently is kidney stones, I think for a five to seven-day course you do what needs to be done for the patient. That includes short and long-acting opioids or acetaminophen injectable. If you are going to use nonsteroidals, I would certainly avoid things like ibuprofen, indomethacin, Toradol. I think a really short course, a five-day course of Celebrex should be okay. It's been shown not to influence kidney function or liver function.

I would just add one thing though. The reason we would like to avoid nonsteroidals in people with decompensation cirrhosis is three-fold. Primarily, it's the concern on kidney function. So even a dose or two of indomethacin or nonsteroidals can precipitously drop GFR in decompensated cirrhotics. That's one. Number two, nonsteroidals make diuretics not really work very well. Diuretic resistance, that's the second. And third being effects on the GI tract. As it is they have fragile GI tract. Giving nonsteroidals can induce bleeding. Those are the three reasons that you would like to avoid nonsteroidals in people with decompensated cirrhosis.

Dr. Buch:
Thank you. So in the last few minutes of our conversation, are there any additional thoughts you'd like to share with our audience?

Dr. Chalasani:
Yeah, there is large perception among our patients, as well as some of our primary care physicians that acetaminophen is dangerous, and thus, we're going to give ibuprofen or nonsteroidals. That is so far from truth. By far the safest analgesic in people with cirrhosis is acetaminophen. The key is limited quantity. And if you can stay within two grams per day, that should be very well tolerated, so that's always my first to go-to analgesic in people with compensated, as well as decompensated cirrhosis.

Dr. Buch:
Thank you. What an important discussion on analgesia and cirrhosis. I want to thank my guest, Dr. Naga Chalasani, for sharing his insights.

Dr. Chalasani, thanks so very much for joining us today.

Dr. Chalasani:
My pleasure to be here and look forward to another conversation.

Dr. Buch:
Absolutely. For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit *GI Insights* and ReachMD, where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.