WALES LIVER DELIVERY PLAN: DOMAIN 4: LIVING WITH LIVER DISEASE

CLINICAL FOLLOW-UP OF PATIENTS WITH CIRRHOSIS

1) **Case ascertainment**
    - All patients believed to have chronic liver disease should be seen at least once by a consultant gastroenterologist with a liver interest. The first encounter will often be as an inpatient.
    - Health Boards should develop registers of all patients with cirrhosis under their care.
    - Some registries allow for periodic blood testing and recall for surveillance by ultrasound.

2) **Outpatient follow-up clinics**
    - Patients with stable cirrhosis may be followed up by Clinical Nurse Specialists in hepatology, but should all have a named consultant with a liver interest.
    - Such nurse specialists may see a wider range of recently decompensated liver disease patients, but it may be helpful for there to be a consultant or experience specialist registrar in an adjacent clinic room.
    - Clinical Nurse Specialists also offer anti-viral therapy and follow-up for patients with chronic viral hepatitis, in addition to ascites management clinics.
    - NICE recommend scoring by MELD every 6 months (model for end-stage liver disease). UKELD scoring is an alternative.
    - For those on non-selective beta blockers (NSBB), the dose is titrated according to systolic blood pressure and a fall in resting heart rate (by 25% or approximating 60 bpm).--

3) **Role of gastroscopy**
    - All patients with cirrhosis should be offered a baseline gastroscopy to look for varices.
    - NSBB are optional in those with grade 1 varices, though those not on beta-blockers should undergo surveillance every 2-3 years.
    - For patients with grade 2+ varices and no history of bleeding, variceal band ligation programmes (VBL) are indicated for patients who cannot tolerate NSBB, or in whom beta-blockers are contraindicated.
    - There is no need to repeat gastroscopic surveillance in well-compensated patients who are tolerating beta-blockers.
    - VBL should be offered to all patients with cirrhosis who have bled from varices. After variceal eradication the timing of further surveillance gastroscopy may be influenced by the aetiology and degree of compensation of the underlying cirrhosis.

4) **Surveillance for hepatocellular carcinoma (HCC)**
    - Ultrasound (USS) is the modality of first choice, and should normally be undertaken every 6 months by a sonographer with training and experience in interpretation of focal and parenchymal liver disease.

- Such surveillance is not indicated in patients whose liver disease is severe and progressive, yet transplantation is not indicated
- Surveillance is also not indicated where performance status and comorbidities would preclude liver transplantation
- There is insufficient evidence for stratifying patients with cirrhosis by aetiology in deciding whether or not to offer surveillance, nor how frequently it should be done.
- Patients with sustained virological responses following antiviral therapy for hepatitis C will normally undergo transient elastography (Fibroscan) at 6-12 months. Those with F3 fibrosis or worse should be offered 6-monthly USS surveillance.
- Similarly patients with chronic hepatitis B and F3 fibrosis or worse should be offered 6-monthly USS surveillance
- Patients with aged >40 years with +chronic hepatitis B without fibrosis but with a family history of HCC should be offered USS surveillance
- Yearly MRI liver is an alternative to USS in patients with macronodular cirrhosis renders USS images difficult to interpret. MRI also has a role in patients whose body habitus and/or small livers hamper surveillance by USS.
- There is little evidence that surveillance of blood for alpha-fetoprotein improves the detection rates of potentially treatable HCC, and the addition of this surveillance is therefore optional.