

## 5.2 Acute liver failure

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Liver failure is likely to present with the following problems:

- Encephalopathy
- Ascites
- Hypoglycemia
- Bleeding
- Overwhelming infections

Such patients usually have signs of chronic liver disease but may have an acute illness with sudden liver failure e.g from paracetamol overdose.

### History & Examination

The history may be clear from relatives with an acute insult on a chronically impaired liver. However there may be no history available or the patient may deliberately try to withhold the truth if a serious attempt at suicide is made.

Examination should concentrate on looking for evidence of chronic liver disease and a search for the cause of the deterioration.

### Investigations

**FBC**

**U&E**

**Clotting**

**Xmatch**

**ABG's**

**CXR**

**MSSU**

**Blood cultures**

### Treatment

**A:** Protect the airway .This may be impaired with encephalopathy and be at risk from vomitus. Get ITU help

**B:** With massive ascites this may be impaired. Aspiration pneumonia is not uncommon in this group of patients. Ventilate as necessary particularly if airway is at risk

**C:** A combination of GI bleeding and clotting disturbance leads to impaired circulation which may be sudden and severe.**Give VitK10mg IV slowly; transfuse FFP, platelets and blood as needed**

**D:** this ranges from lethargy and confusion to a GCS of 3.

- Measure blood glucose every 4hrs and treat hypoglycemia.
- Treat infections seriously; Gentamicin, metronidazole and penicillin until sensitivities are known.
- Avoid protein meals and decontaminate the bowel with neomycin, lactulose and enemas
- Consider the use of N acetyl-cysteine (seek senior help from the Gastro Reg)

- Watch for GI bleeding

**A patient in coma with clotting and electrolyte disturbance needs to be nursed in an ITU environment.**

### **5.3 Swallowed foreign body**

This is common particularly in children. In adults it is largely accidental whilst eating a meal although there are a number of frequent attenders who deliberately ingest items such as shards of glass, nails, and other sharp objects.

The majority of items swallowed by children are passed by them easily. It is important to ascertain the nature of the FB as this will guide management. Time from ingestion as well as the presence of abdominal ?chest pain, cough, vomiting and constipation will guide whether further investigations and opinion is required.

A coin ingested by a child without symptoms requires strong reassurance and advice regarding a stool watch

However patients with abdominal pain following ingestion of a sharp object will need further imaging and a surgical opinion.

A special case is button batteries ;these need removal if in the oesophagus, therefore X-ray chest and abdo. Should not be left in the stomach for more than 24-48 hours depending on the type (the info file will guide here). Once past the pylorus. Don't worry unless the battery appears ruptured or broken on X-ray. A magnet/NG tube is manufactured and this is worth trying for gastric removal.

### **Inhaled foreign body**

These present an entirely different problem and should be relentlessly localised. Inhalation of a FB is always associated with coughing or choking affect. and can cause acute respiratory distress if impacted in the larynx from which they are best expelled by the Heimlich manoeuvre. Always consider the risk of aspiration in the collapsed patient. They can lodge in the pharyngeal recesses or pass the larynx and into the lungs causing segmental collapse, bronchiectasis abcess etc.

A high degree of suspicion is required and Xrays should be taken of the soft tissues of the neck and the chest. If the Xrays are normal and the patient is still symptomatic ask for an ENT opinion.