The Association for Clinical Biochemistry & Laboratory Medicine

Better Science, Better Testing, Better Care

Summary of NICE Guidelines

Title	Cirrhosis in over 16s: assessment and management
NICE Reference	NG50
Date of Review:	December 2017
Date of Publication	July 2016
Summary of Guidance (Max 250 words)	This guideline is for the diagnosis and management of people at risk of cirrhosis whom remain asymptomatic until liver failure begins. **Diagnosis:** Risk of cirrhosis is increased by hepatitis B (HBV) and hepatitis C (HCV) infection, alcohol abuse, obesity (BMI ≥ 30), and type 2 diabetes. Non-alcoholic fatty liver disease (NAFLD) and advanced liver fibrosis (enhanced liver fibrosis test score ≥10.51) are also indications for assessment (see also NG49). Diagnosis may be performed by transient elastography (TE) and/or acoustic radiation force impulse imaging, depending on the clinical context. Liver biopsies are recommended if TE is not suitable. Obese patients should not be offered diagnosis, unless they have other signs of cirrhosis. Routine liver function profiles should not be used to rule out cirrhosis. Retesting is recommended every two years for patients with liver disease but who are negative for cirrhosis, and HCV patients who lack a sustained response to antiviral therapy. **Monitoring:** A score of ≥12 under the Model for End−Stage Liver Disease (MELD) indicates high risk of complications from cirrhosis. Ultrasound should be offered to cirrhotic patients without HBV every 6 months as surveillance for hepatocellular carcinoma (for patients with HBV, see CG165). Surveillance should not be offered to patients receiving end of life care. Patients diagnosed with cirrhosis should be offered upper gastrointestinal endoscopy to detect oesophageal varices, with surveillance every three years. **Managing Complications:** • Medium/large oesophageal varices: offer endoscopic variceal band ligation. • If upper gastrointestinal bleeding: consider prophylactic intravenous antibiotics (see NG15: 1.1). • Refractory ascites: consider transjugular intrahepatic portosystemic shunts. • Ascitic protein ≤ 15 g/L: consider offering prophylactic oral ciprofloxacin, or norfloxacin.

Impact on Lab (See below)	☒ Moderate
Lab professionals to be made aware	☐ Chemical Pathologist ☐ Clinical Scientist
Please detail the impact of this guideline (Max 150 words)	An awareness of diagnostic procedures will be useful for understanding test requests in the context of cirrhosis. This guideline refers to guidance on assessment and management of NAFLD (NG49), which mentions the use of the enhanced liver fibrosis test (ELF) to determine whether diagnosis should be performed. The ELF test combines measurement of three fibrosis markers (TIMP-1, PIIINP, and HA) in serum, and so demand for these tests may increase following implementation of this guideline. It is important to note that while routine liver laboratory testing is not recommended for diagnosis of cirrhosis, the condition is directly linked to other conditions routinely diagnosed and monitored in the laboratory, including alcohol misuse, diabetes, liver disease, and hepatitis B/C. Furthermore, the MELD score is calculated using measurement of serum bilirubin, serum creatinine and INR. As these are already routinely measured in cirrhotic patients, the demand for these tests should not increase significantly as a result of these guidelines.

Impact on Lab

- **None**: This NICE guideline has no impact on the provision of laboratory services
- **Moderate**: This NICE guideline has information that is of relevance to our pathology service and may require review of our current service provision.
- **Important:** This NICE guideline is of direct relevance to our pathology service and will have a direct impact on one or more of the services that we currently offer.

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