Hepatic Encephalopathy in Chronic Liver Disease

Classification/diagnosis, general treatment principles, episodic OHE treatment, recurrence prevention, MHE/CHE, and nutrition.

2014 AASLD/EASL Practice Guideline
Hepatic Encephalopathy in Chronic Liver Disease
Vilstrup, Amodio, Bajaj et al. · Hepatology 2014;60:715

STRENGTH — Strong (1) — Weak (2)

1 Classification & Diagnosis

STATEMENT	STRENGTH
R1 — Classify HE by underlying disease type, severity, time course, and precipitating factors	Strong Level III·A
R2 — Diagnostic workup required, considering other disorders that can mimic HE	Strong Level II-2·A
R3 — Treat HE as a continuum from unimpaired cognition through coma	Strong Level III·A
R4 — HE diagnosis is by exclusion of other causes of brain dysfunction	Strong Level II-2·A
R5 — Divide HE into severity stages reflecting self-sufficiency and care needs	Strong Level III·B
R6 — Diagnose overt HE (OHE) by clinical criteria; grade via West Haven Criteria and GCS	Strong Level II-2·B
R7 — Diagnose/grade MHE and CHE using neurophysiological/psychometric tests performed by experienced examiners	Strong Level II-2·B
R8 — Test for MHE/CHE in patients who would benefit most (impaired QoL, employment/public-safety implications)	Weak Level III·B
R9 — Blood ammonia alone adds no diagnostic/staging/prognostic value; a normal value should prompt diagnostic reevaluation	Strong Level II-3·A

2 General Treatment Principles

STATEMENT	STRENGTH
R10 — Actively treat every OHE episode (spontaneous or precipitated)	Strong Level II-2·A
R11 — Secondary prophylaxis is recommended after an overt HE episode	Strong Level I·A
R12 — Primary prophylaxis not required except in cirrhosis with known high HE risk	Weak Level II-3·C
R13 — Recurrent intractable OHE with liver failure is an indication for LT	Strong Level I
R14–17 — Four-pronged OHE approach: initiate care for altered consciousness; seek/treat alternative causes of mental status change; identify/correct precipitating factors; start empirical HE treatment	Strong Level II-2·A

3 Treatment of Episodic OHE

STATEMENT	STRENGTH
R18 — Identify and treat precipitating factors for HE	Strong Level II-2·A
R19 — Lactulose is first choice for treatment of episodic OHE	Strong Level II-1·B
R20 — Rifaximin is effective add-on therapy to lactulose to prevent OHE recurrence	Strong Level I·A
R21 — Oral BCAAs as alternative/additional agent for patients nonresponsive to conventional therapy	Weak Level I·B
R22 — IV L-ornithine L-aspartate (LOLA) as alternative/additional agent for nonresponders	Weak Level I·B
R23 — Neomycin is an alternative choice for OHE treatment	Weak Level II-1·B
R24 — Metronidazole is an alternative choice for OHE treatment	Weak Level II-3·B

4 Prevention of Recurrent OHE

STATEMENT	STRENGTH
R25 — Lactulose is recommended for prevention of recurrent HE episodes after the initial episode	Strong Level II-1·A
R26 — Rifaximin add-on to lactulose is recommended for prevention after a second episode	Strong Level I·A
R27 — Routine prophylactic therapy (lactulose or rifaximin) is not recommended for prevention of post-TIPS HE	Strong Level III·B
R28 — Prophylactic therapy may be discontinued once precipitating factors are well controlled or liver/nutritional status improves	Weak Level III·C

5 Treatment of Minimal & Covert HE

STATEMENT	STRENGTH
R29 — Treatment of MHE/CHE is not routinely recommended, apart from case-by-case basis	Strong Level II-2·B

6 Nutrition

STATEMENT	STRENGTH
R30 — Daily energy intake 35–40 kcal/kg ideal body weight	Strong Level I·A
R31 — Daily protein intake 1.2–1.5 g/kg/day	Strong Level I·A
R32 — Offer small meals or liquid nutritional supplements evenly distributed through the day plus a late-night snack	Strong Level I·A
R33 — Oral BCAA supplementation may help achieve/maintain recommended nitrogen intake in patients intolerant of dietary protein	Weak Level II-2·B

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