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<https://reachmd.com/programs/cme/Treatment-of-Hepatic-Encephalopathy-When-What-How-and-Why/39790/>

Released: 12/11/2025

Valid until: 12/11/2026

Time needed to complete: 55m

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Treatment of Hepatic Encephalopathy: When, What, How, and Why?

Announcer:

Welcome to CE on ReachMD. This activity is provided by TotalCME and is part of our MinuteCE curriculum.

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Dr. Jesudian:

This is CE on ReachMD, and I'm Dr. Arun Jesudian. How do we approach treating hepatic encephalopathy?

If you imagine a patient with overt hepatic encephalopathy in the emergency department, the first step is to provide supportive care for their altered mental status the same way we would any patient with altered consciousness, and that can involve intubation for airway protection if this episode is particularly severe. We then exclude other causes of altered mental status, such as brain bleeds or seizures or taking medications that can affect their consciousness.

Once we've ruled those out and made the diagnosis of overt hepatic encephalopathy, a very important step is to identify and address precipitating factors to this episode. What I mean by that is that if the patient with hepatic encephalopathy is worse today than they were yesterday, or if this is a new-onset episode of overt hepatic encephalopathy, we have to think about other processes going on, many of which could be life-threatening.

Common ones include infections. That could be everything from infection of ascites fluid to bloodstream infections or pneumonias or UTIs. We also think about GI bleeding, variceal and other GI bleeding, where blood in the intestinal tract is a protein load for bacteria, generating ammonia. Kidney and electrolyte problems are common precipitants. Sedating medications such as those taken for sleep or anxiety could be contributing. Patient nonadherence with hepatic encephalopathy therapies is common, particularly lactulose—the laxative that is a first-line therapy for hepatic encephalopathy—can be difficult for some patients to take. It's also important to think about portal vein thrombosis or hepatocellular carcinoma and other issues in the liver that could be picked up with imaging, like an ultrasound.

So we need to identify and address those precipitants and then focus on treating the hepatic encephalopathy itself with ammonia-lowering agents. The first line, again, is lactulose, the laxative that can promote bowel movement so there's less bacteria generating ammonia, and it can also acidify the colon and make the ammonia less likely to be absorbed and cross the blood-brain barrier.

Rifaximin is usually added to lactulose, particularly in patients who have had a recurrent episode of overt hepatic encephalopathy while on lactulose. Rifaximin is a poorly absorbable or nonabsorbable antibiotic that decreases the bacterial burden in the colon so that less ammonia is being generated.

What's also important to talk to your patients about, particularly as they recover, is the importance of nutrition and especially protein

intake in treating their hepatic encephalopathy. Traditional teaching about hepatic encephalopathy used to say limit dietary protein intake so that there's less protein around to generate ammonia.

The reality is that protein intake is important in this situation. Patients with cirrhosis commonly have sarcopenia or muscle breakdown. And skeletal muscle is an important source of nitrogen or ammonia. So we do not want these patients to limit their dietary protein—that doesn't seem to impact hepatic encephalopathy much at all, because we want them to continue to maintain their skeletal muscle mass and not become sarcopenic. This can help address their hepatic encephalopathy, but can also keep them more functional and robust, particularly if they're heading towards, say, a liver transplant as a cure for their decompensated cirrhosis and overt hepatic encephalopathy. So I tell my patients to eat small meals during the day, including protein, and, particularly at bedtime, a protein-rich snack is very important to offset this muscle loss.

So if you take one thing away, treat malnutrition and sarcopenia.

Well, this has been a great bite size discussion. Our time is up. Thanks for listening.

Announcer:

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