ACUTE LIVER FAILURE

Sudden and severe liver cell dysfunction, coagulability, and hepatic encephalopathy

Causes: infections, toxins, drug use, medication toxicity, poisoning, hypoperfusion, metabolic disorders, surgery

High mortality

DIAGNOSING ACUTE LIVER FAILURE

EARLY RECOGNITION IS KEY!

Signs/Symptoms: headache, jaundice,changes in mental status, bruising, bleeding, palmar erythema, elevated bilirubin, ammonia, decreased albumin, prothrombin time is elevated and plasmin and platelets are decreased

HEPATIC ENCEPHALOPATHY STAGES

I. Euphoria vs depression, mild confusion, slurred speech, disordered sleep, slight asterixis, normal EEG

II.Lethargy, moderate confusion, marked asterixis, abnormal EEG

III.Marked confusion, incoherent speech, sleepy but arousable, asterixis present, abnormal EEG

IV.Coma, responsive then nonresponsive to painful stimuli, asterixis absent, abnormal EEG

MANAGEMENT FOR ACUTE LIVER FAILURE

Antibiotic: neomycin, metronidazole,rifaximin Lactulose Prevent bleeding with vitamin K, FFP, platelets Monitor for infection Protect patient from injury Monitor for complication Education

SURGICAL MANAGEMENT: Esophagectomy Pancreaticoduodenectomy, Endoscopic variceal litigation, Endoscopic injection therapy, Trans jugular intrahepatic portosystemic shunt procedure

PHARMACOLOGICAL TREATMENT

Antacids, PPIs, H2 antagonist, Sucralfate, Vasopressin, Octreatide

ACUTE GI HEMORRHAGE

CLINICAL MANIFESTATIONS	ASSESSMENT FINDINGS AND DIAGNOSIS FOR GI BLEED	MEDICAL MANAGEMENT FOR GI BLEED
Stress related mucosal disease: seen a lot because increase acid, decreased mucosal flow	Melena: digestion of blood from upper GI bleed (purplish red clotty blood)	Maintain Airway, Fluid Resuscitation
Bleeding in upper or lower GI tract	Hematemesis: vomit blood(coffee ground or bright red)	Any patients in ICU at risk
Peptic ulcer disease	Hematochezia: blood in the stool lower GI bleed	Administer prophylactic medications: PPIs, Histamine 2 antagonist
Esophageal varices: blood vessels in esophagus increase in size and rupture (cirrhosis)	Hbg and Hct is not going to determine bleeding, severity will based off patient	Determine cause of bleeding, control and stop bleeding

ABDOMINAL TRAUMA

Often associated with multisytem trauma

Blunt or penetrating

PHYSICAL ASSESSMENT AND DIAGNOSIS

Abdominal distention, Cullen Sign, Grey-Turner sign, hypoactive or absent bowel sounds, rebound tenderness, Kerrs sign, entry/exit wounds

ABDOMINAL TRAUMA (cont)

Focused assessment, CT scans, abdominal x-rays, peritoneal lavage

COMPLICATIONS

Abdominal compartment syndrome

Increased pressure causes decreased blood flow leading to ischemia and necrosis

Decreased CO, decreased UOP,hypoxia

May need to leave abdomen open after surgery to prevent occurence

Live Injuries

Hemorrhage is very common

Often hemodynamically unstable

Jaundice, coagulopathy, acidosis, hypthermia contribute

Spleen Injuries

Sometimes hemodynamically unstable

Often attempt to embolize instead of remove spleen

Patients with splenectomy at high risk for infection

Hollow viscus Injuries

Stomach, Small and Large Intestine

Often hard to see/diagnosis

Can lead to peritonitis

Kidney Injuries

May see flank ecchymosis

May see gross or microscopic hematuria

Bladder Injuries

Usually because of pelvic fractures

Patients complain of difficulty or inability to void

Conservative treatment is catheterization and antibiotics

Pelvic Fractures

High mortality due to large area that is highly vascular

Can be stable or unstable

May indicate more severe injuries such as SCI

ACUTE PANCREATITIS

CLINICAL MANIFESTATIONS	ASSESSMENT FINDINGS	DIAGNOSTICS	MANAGEMENT
Acute Inflammation that produces exocrine and endocrine dysfunction that may also involve surrounding tissues	Pain, N/V, fever, guarding of abdomen	Labs:amylase, lipase,c-reactive protein, WBC, decreased calcium,bilirubin high, decreased albumin	Replace fluid volume loss/s-hifts, closely monitor electroly-tes/glucose levels

ACUTE PANCREATITIS (cont)			
80% have edematous interstitial pancreatitis (less severe)	Hypovolemic shock, absent bowel sounds, grey turner's sign	Abdominal ultrasound of gallstones	Monitoring complications, using NGT only if patient has vomiting, obstruction, or severe gastric distention
20% have necrotizing pancreatitis (more severe)	Jaundice, ascites, Cullen's signs, abdominal mass	CT scan for inflammatory/necrosis	Provide emotional support and education, Nutritional support