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**Prevalence and outcome
of cirrhosis patients admitted
to UK intensive care:
a comparison against dialysis-
dependent chronic renal failure
patients: response to Berry
and Thomson**

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This reply refers to the comment available
at: doi:[10.1007/s00134-012-2631-z](https://doi.org/10.1007/s00134-012-2631-z).

Dear Editor,
I thank Drs. Berry and Thompson for their comments and accept that the tone of the discussion in our article [1] was indeed negative. However, I feel that this was an accurate reflection of the data presented. I do share their concerns that the paper might be regarded as championing “therapeutic nihilism” in cirrhosis patients, in particular those with sepsis. This was not my intention. Rather, I feel that the onset of multi-organ failure (MOF) is such a catastrophic event in these patients that we should focus on the early phase of the illness, as indeed Drs. Berry and Thompson

suggest. Whether this is in a high-dependency environment or acute medical admissions unit will depend on the resources available. Regrettably, beyond supportive measures such as fluid resuscitation, nutrition, terlipressin and appropriate antibiotics, there is little to offer at present, but these measures have been demonstrated to improve outcome. I believe that hepatologists need to be more proactive and educate the acute admitting teams as these first 24 h are often crucial.

The authors also make several other points I'd like to address:

As I acknowledge in the paper, the comparison between renal failure and liver failure is most definitely imperfect. However, I feel that to suggest that renal failure often remains isolated from other organs is misleading given the well-established association with cardiovascular disease which remains the most common cause of death in the UK. That nutritional status is a key determinant of survival has been known for several decades, yet nutritional therapy is often overlooked and suboptimal in cirrhosis patients, and the authors are right to highlight this. However, the argument that we should disregard the severe mortality figures of MOF in cirrhosis simply because liver disease is increasing in the UK and affecting younger people is not logical and I cannot agree with this statement. The causes of this epidemic of liver

disease are well documented and will require a multidisciplinary strategy involving hospital workers, addiction specialists, and those in public health, government and the food and drinks industry among others to tackle successfully.

I wish to conclude on a note of optimism—as stated the survival figures are improving and increased clinical and laboratory research into this area will improve treatment yet further. However, it is difficult at present to envisage this happening in patients with established MOF, and I believe that we should focus our attention on patients at risk of organ failure as I feel the greatest gains will occur here.

Reference

1. O'Brien AJ, Welch CA, Singer M, Harrison DA (2012) Prevalence and outcome of cirrhosis patients admitted to UK intensive care: a comparison against dialysis-dependent chronic renal failure patients. *Intensive Care Med* 38:991–1000. doi: [10.1007/s00134-012-2523-2](https://doi.org/10.1007/s00134-012-2523-2)

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