

CytoSorb®



Best practice flowchart liver dysfunction



Patient selection

- Bilirubin > 10 mg/dl (> 170 $\mu\text{mol/l}$)
- Hepatic encephalopathy grade ≥ 2
- Acute Liver Failure or Acute-on-Chronic Liver Failure grade 2-3
- Concomitant vasoplegic shock not responding to standard therapy (best to be used within first 24 hrs.)
- Onset of liver failure after surgery or transplantation
- Intractable pruritus



Timing

Integrate CytoSorb® in hemoperfusion, CRRT or ECMO



Dosing

Consider changing the adsorber after 8 hours until sufficient stabilization / clinical improvement is seen



Ongoing liver dysfunction
without irreversible organ damage

Re-Evaluation
at regular intervals

Standard therapy
continuation

Potential criteria to decide on CytoSorb®

- Bilirubin ≥ 10 mg/dl (170 μ mol/l)
- Hepatic encephalopathy HE grade ≥ 2
- Refractory septic / vasoplegic shock
- Signs of hyperinflammatory response (PCT $> 3\mu$ g/l, CRP > 100 mg/l)

NO

Integrate CytoSorb®

- > Hemoperfusion
- > CRRT
- > ECMO

Consider complex coagulation status **

BEGIN
CytoSorb®



8 hrs.*

2nd
Adsorber



8 hrs.*

3rd
Adsorber



8 hrs.*

New
Adsorber



12-24 hrs.*

* Depending on the individual's clinical course (e.g. persistent pronounced reduction in bilirubin levels) it may be possible to deviate from the indicated times to longer intervals or even terminate the therapy earlier. If feasible, please consider consecutive pre- and post-adsorber blood sampling as aid for assessing saturation of the adsorber. Sufficient control of the underlying cause is a prerequisite for therapeutic success.

Signs of sufficient clinical stabilization e.g.
Bilirubin < 8 mg/dl (136 μ mol/l)
Significant improvement in HE
Shock reversal
Control of hyperinflammation

YES

STOP
CytoSorb®

** Anticoagulation must be carefully implemented. Do not rely solely on PT or INR values.



Learn more in detail
cyto.zone/setup