https://doi.org/10.47102/annals-acadmedsg.2026451

ASCITES: A framework supporting gastroenterologists to deliver primary palliative care for patients with decompensated cirrhosis

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Dear Editor,

Decompensated cirrhosis is a life-limiting condition with a high symptom burden and poor prognosis, with median survival often <2 years,[1] and symptom severity comparable to cancer, chronic obstructive pulmonary disease, and heart failure.[2] Yet palliative care uptake remains low and is typically introduced too late.[3] In Singapore, decompensated cirrhosis affects an estimated 175–200 per 100,000 population and contributes substantially to life-years lost.[4] Although recognition of palliative care needs has increased, workforce and resource constraints limit specialist involvement, highlighting the need to integrate palliative care into routine hepatology practice.

Primary palliative care, defined as core palliative competencies delivered by non-specialist clinicians,[5] represents such an approach. Gastroenterologists are well positioned to provide this care given their longitudinal relationships with patients and caregivers across clinic visits, hospitalisations, and disease transitions. However, barriers to integration include prognostic uncertainty, limited patient and caregiver understanding of palliative care, clinician discomfort with advance care planning, and competing priorities such as transplant evaluation.[5] The absence of a clear, practical structure for incorporating these elements may further limit clinician confidence and consistency.

These challenges do not reflect a lack of recognition of palliative care's value among gastroenterologists. Preliminary findings from a qualitative study of gastroenterologists' perspectives on palliative care integration (authors' unpublished data) suggest that they broadly value specialist palliative care and its benefits for symptom management, psychosocial support, and caregiver burden, often citing a professional responsibility to address these needs. Nevertheless, translating this recognition into practice remains challenging: gastroenterologists describe the cognitive effort of shifting from a curative, problem-solving orientation to goals-of-care discussions, alongside lower self-efficacy in addressing psychosocial needs and navigating family resistance. This suggests a role for approaches that provide greater structure and support.

To provide such structure, the authors propose **ASCITES**: **A**dvance care planning, **S**ymptom control, **C**aregiver support, **I**nformation sharing, **T**reatment rationalisation, **E**ngagement of a multidisciplinary team, and **S**pecialist palliative care referral. ASCITES is intended to help gastroenterologists systematically incorporate palliative principles into routine practice. The framework was developed by synthesising American Association for the Study of Liver Diseases,[5] European Association for the Study of the Liver,[6] and American Gastroenterological Association[7] guidance with consensus discussion among the author group, who have clinical experience in hepatology and palliative care. Rather than being derived through a

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Accepted: 26 October 2026
Published Online First: 18 November 2026

Table 1. The ASCITES framework — domains and triggers.

Letter	Domain	Trigger/focus
A	Advance care planning	Initiate early, led by the primary gastroenterologist; revisit as disease progresses or capacity changes.
S	Symptom control	Actively screen for physical and psychological symptoms (e.g. pain, pruritus, fatigue, anxiety) using validated tools such as the Edmonton Symptom Assessment Scale.
C	Caregiver support	Routinely assess caregiver burden; connect caregivers to counselling, peer support and respite care.
I	Information sharing	Communicate disease trajectory and prognosis clearly, sensitive to family-centred decision-making norms.
T	Treatment rationalisation	Review and deprescribe medications in line with goals of care and the evolving benefit-harm balance.
E	Engagement of multidisciplinary team	Coordinate nursing, allied health and case-management input; hold regular multidisciplinary review.
S	Specialist palliative care referral	Escalate to specialist or home-based palliative care for refractory symptoms, complex decision-making, or difficult family dynamics.

formal Delphi process, ASCITES maps core palliative principles onto the familiar structure of a clinical consultation, designed for busy settings. The 7 domains are interconnected rather than sequential or standalone, forming a checklist to be adapted to each patient and family. Among patients with decompensated cirrhosis identified as having palliative care needs using tools such as the Supportive and Palliative Care Indicators Tool, the surprise question, or the Bristol Prognostic Score,[6] a systematic symptom assessment and early serious illness conversation should be triggered. These discussions inform advance care planning and alignment of care with patient goals, which guide treatment rationalisation and timely multidisciplinary involvement, while specialist referral provides an additional layer of support for patients with increasing complexity (Table 1). Where available, a dedicated cirrhosis hotline may further support timely intervention and reduce unnecessary hospital presentations.

Symptom assessment should extend beyond commonly recognised complications such as ascites, variceal bleeding, and hepatic encephalopathy to include less visible symptoms including fatigue, pruritus, sleep disturbances, anxiety, and depression, which are frequently overlooked despite their impact on quality of life. Caregiver support is similarly integral: caregivers of patients with cirrhosis experience substantial, often under-recognised burden, which may be compounded by alcohol or substance use issues and can affect their own health over time.[8] Routine assessment of caregiver burden and access to counselling, peer support, and respite care should be an integral component of care rather than an optional adjunct. Information sharing on prognosis must also be handled with cultural sensitivity: in many Asian societies, including Singapore, norms favouring family-centred decision-making should be navigated carefully, balancing patient autonomy with family dynamics.[9]

ASCITES has not yet been formally piloted. Potential implementation strategies include an electronic medical record smart phrase to prompt and document its use, dissemination through gastroenterologist training and clinical champions, incorporation into fellowship teaching, and periodic audit and feedback. Prospective evaluation should examine feasibility alongside clinical outcomes, including advance care planning completion, symptom burden, caregiver well-being, clinician self-efficacy, and healthcare utilisation. Implementation science frameworks may further help determine how this approach works, for whom and under what conditions, informing sustainable adoption across diverse hepatology settings.

In Singapore, where specialist palliative care capacity remains limited, patients with decompensated cirrhosis and identified palliative care needs should first receive gastroenterologist-delivered primary palliative care. Substantial palliative care needs may exist even among patients who remain ambulant and relatively independent, underscoring the need for routine needs-based assessment rather than reliance on functional decline alone. Specialist palliative care should complement rather than replace primary palliative care, directing expertise towards patients with greater complexity. Home-based palliative care may represent a subsequent step for selected patients, particularly those with limited mobility, increasing care needs, or a preference for community-based care; a Singapore feasibility study of home-based palliative care for end-stage liver disease is underway and may clarify this landscape.[10]

Beyond ASCITES itself, wider adoption of primary palliative care within hepatology will require system-level enablers: validated needs-based screening tools, institutional support for multidisciplinary collaboration, and appropriate funding mechanisms, alongside dedicated resources such as specialist nurse support, care coordinators, and access to community and home-based services. Collaborative models integrating hepatology and specialist palliative care may further enhance quality of life and reduce unnecessary healthcare utilisation.

In summary, the persistent gap in quality end-of-life care for patients with decompensated cirrhosis underscores the need for gastroenterologists to develop skill sets to deliver primary palliative care earlier in the disease trajectory. Care should be grounded in the bio-psycho-social-spiritual model, which extends beyond patients' physical symptoms. ASCITES provides a practical framework to support this shift by embedding core palliative care principles within routine hepatology practice. High-quality palliative care should be a shared responsibility, initiated early by the gastroenterologist, supported by multidisciplinary care, and complemented by specialist, community, and home-based palliative care as patients' needs become more complex.

Ethics statement

Not applicable as no patient data were used.

Declaration

No funding was received for this study. The authors declare that they have no affiliations or financial involvement with any commercial organisation with a direct financial interest in the subject or materials discussed in the manuscript. Generative artificial intelligence (AI) tools were used solely to assist with language refinement, editing and improvement of readability. AI technologies were not used to generate scientific content, formulate arguments, analyse data, interpret findings, or draw conclusions.

Keywords: *gastroenterology, internal medicine, palliative medicine, quality of life, sarcopenia*

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