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Along with the le heart, the right ventricular dysfunction needs further focus. To determine whether there is intrapulmonary shunting when chronic and increasing hypoxia is present, contrast echocardiography should be carried out. When the right ventricular systolic pressure (RVSP), as determined by normal TTE, is greater than 45 mmHg, right heart catheterization is indicated [3].

Respiratory drive

In ACLF, hepatic encephalopathy (HE) is very common. e risk of mortality and morbidity increases with increasing HE grades. 18 When brain failure is severe, it can lead to respiratory arrest and airway desensitisation, which raises the possibility of aspiration and subsequent infection. Even though routine head computed tomography (CT) scans in HE patients with neurologic deterioration are debatable they may be useful in determining prognosis in cases where respiratory drive is compromised, such as ischemic or hemorrhagic brain stem stroke or hernia a er cerebral edoema [4].

e PFT is a thorough assessment of ventilation that can identify coexisting lung illnesses including COPD and ILD. Peak expiratory ow, forced expiratory volume in the rst second (FEV1), and vital capacity can all be utilised to predict how well a transplant will go and how well a patient will respond to rehabilitation. An important integrated test method for assessing lung function is the submaximal exercise experiment. 30 e 6-minute walk test (6MWT) and the associated modi ed Borg scale (today, the modi ed Borg scale, 0-10 score, higher scores indicate more severe dyspnoea or tiredness) are the two extensively used easy procedures for assessing cardiopulmonary function during rehabilitation. Before walking, patients' dyspnoea and