ACHHEP
Asociación Chilena
de Hepatología

Enfrentamiento práctico en asctis de reciente comienzo asociada a cirrosis.

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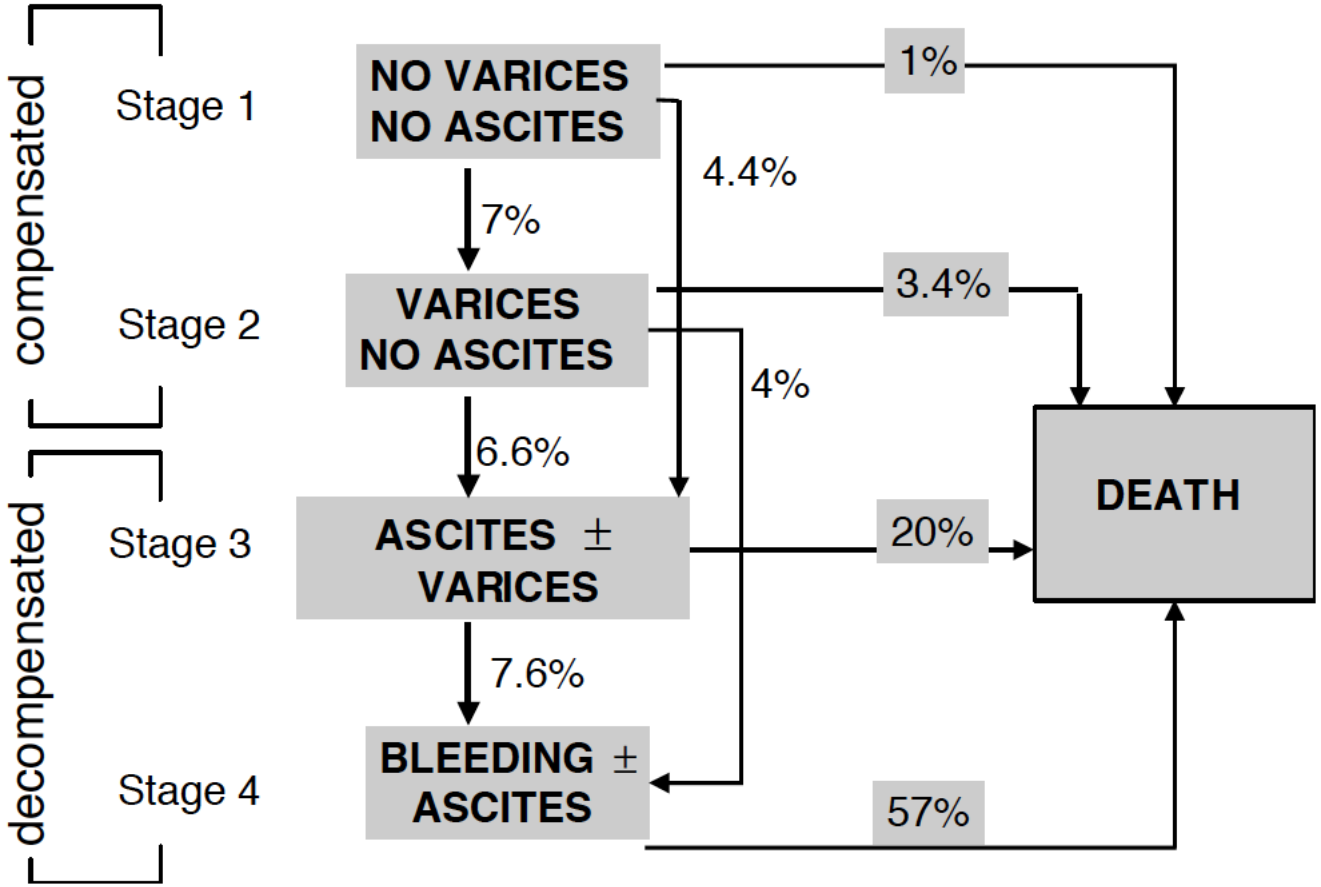
Ascitis

- Causa mas común de descompensación en cirrosis.
  - Se produce en 5–10% /año de pacientes con cirrosis compensada.
- Impacto significativo en los pacientes.
  - Disminuye vida social y capacidad de trabajo.
  - Frecuentemente es causa hospitalización.
  - En general requiere tratamiento crónico.
  - Causa directa de otras complicaciones.
  - Pronóstico limitado…

EASL CPG decompensated cirrhosis. J Hepatol 2018;doi: 10.1016/j.jhep.2018.03.024


compensated
decompensated
Stage 1
Stage 2
Stage 3
Stage 4
NO VARICES
NO ASCITES
VARICES
NO ASCITES
ASCITES ±
VARICES
BLEEDING ±
ASCITES
DEATH
1%
4.4%
7%
3.4%
4%
6.6%
20%
7.6%
57%

Ascitis : Evaluación y diagnóstico

- Cirrosis es responsable del 80% de los casos de ascitis
- Ascitis es graduada en base a cantidad de líquido.

Grading of ascites*	
Grade 1	Mild ascites: only detectable by ultrasound examination
Grade 2	Moderate ascites: manifest by moderate symmetrical distension of abdomen
Grade 3	Large or gross ascites: provokes marked abdominal distension

*Ascites recurring on ≥3 occasions within a 12-month period despite dietary sodium restriction and adequate diuretic dosage are considered recurrent

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Ascitis no complicada se refiere a la ausencia de infección del líquido, deterioro de la función renal y/o refractaria a tratamiento

- Cuadro clínico general
- Función hepática
- Función renal
- Electrolitos plasmáticos
- Punción ascítica

IMAGEN
- Hepatoma
- Trombosis portal

Ascitis no complicada : Evaluación y diagnóstico

- Paracentesis diagnóastica está indicada en :*
  - Todo paciente sin historia previa de ascitis (grado 2 o 3)
  - Pacientes hospitalizados por empeoramiento de su ascitis u otra complicación de la cirrosis.

Recommendation	Grade of evidence	Grade of recommendation
Neutrophil count and culture of ascitic fluid culture† should be performed to exclude **bacterial peritonitis** • Neutrophil count >250 cells/µl denotes SBP	II-2	1
Ascitic total protein concentration should be performed to identify patients at higher risk of developing SBP‡	II-2	1
The SAAG should be calculated when the cause of ascites is not immediately evident, and/or when conditions other than cirrhosis are suspected§	II-2	1
Cytology should be performed to differentiate malignancy-related from non-malignant ascites	II-2	1

*Grade of evidence II-2, grade of recommendation 1; †Bedside inoculation blood culture bottles with 10 ml fluid each;
‡A total protein concentration <1.5 g/dl is generally considered a risk factor for SBP;
§SAAG ≥1.1 g/dl indicates that portal hypertension is involved in ascites formation with an accuracy of about 97%
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Ascitis no complicada : Tratamiento

- **Grado 1** o ascites leve
  - No hay datos de si tratarla influye en evolución o pronóstico
- **Grado 2** o ascites moderada
  - Hospitalización no requerida
  - Corregir el desequilibrio del sodio :
    - Restricción dietética y aumento de excreción urinaria (diuréticos)

Recommendation	Grade of evidence	Grade of recommendation
Moderate restriction of sodium intake (80–120 mmol/day, corresponding to 4.6–6.9 g of salt) is recommended	I	1
Generally equivalent to a no added salt diet with avoidance of pre-prepared meals. Adequate nutritional education of patients on how to manage dietary sodium is also recommended	II-2	1
Very low sodium diets (<40 mmol/day) should be avoided	II-2	1
Prolonged bed rest cannot be recommended	III	1

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Consideraciones antes de iniciar diuréticos :

- Pacientes con cirrosis y ascitis son altamente suceptibles a cambios rápidos del VEC
  - Pueden hacer falla renal y/o encefalopatía.

Recommendation	Grade of evidence	Grade of recommendation
GI haemorrhage, renal impairment, hepatic encephalopathy, hyponatraemia, or alterations in serum potassium concentration, should be corrected before starting diuretic therapy • In these patients, cautious initiation of diuretic therapy and **frequent** clinical and biochemical **assessments** should be performed	III	1
Diuretic therapy is generally **not recommended** in patients with **persistent overt hepatic encephalopathy**	III	1

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Ascitis no complicada : Recomendación de diuréticos :

- La primera elección son los diuréticos anti-aldosterónicos (Espironolactona)
- Diuréticos de asa como la Furosemida pueden ser agregados …

Recommendation	Grade of evidence	Grade of recommendation
First episode of grade 2 ascites • Anti-mineralocorticoid drug alone (from 100 mg/day with 100 mg stepwise increased every 72 hours to a maximum of 400 mg/day if no response to lower doses)	I	1
In **patients who do not respond to anti-mineralocorticoids†** or who develop hyperkalaemia, furosemide should be added (from 40 mg/day with 40 mg stepwise increases to a maximum of 160 mg/day)	I	1
Long-standing or recurrent ascites • Combination of an anti-mineralocorticoid drug and furosemide (dose increased sequentially according to response)	I	1

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Monitoreo de pacientes recibiendo diuréticos

- Diureticos de asa pueden provocar depleción de potasio / magnesio e hiponatremia
- Calambres pueden reducer la calidad de vida.

Recommendation	Grade of evidence	Grade of recommendati
Frequent clinical and biochemical monitoring during the first weeks of treatment (particularly on first presentation)	I	1
Recommended maximum weight loss: 0.5 kg/day in patients without oedema, 1 kg/day in patients with oedema	II-2	1
Once ascites have largely resolved, the dose of diuretics should be reduced to the lowest effective dose	III	1
Discontinue diuretics in case of severe hyponatraemia,* AKI, worsening hepatic encephalopathy, or incapacitating muscle cramps	III	1
Discontinue furosemide for severe hypokalaemia (<3 mmol/L) Discontinue anti-mineralocorticoids for hyperkalaemia (>6 mmol/L)	III	1
Albumin infusion or baclofen administration† are recommended in patients with muscle cramps	I	1

*Serum sodium <125 mmol/L; †10 mg/day, with a weekly increase of 10 mg/day up to 30 mg/day
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Ascitis no complicada, pronóstico :

- Desarrollo de ascitis en pacientes con cirrhosis se asocial a mal pronóstico :
  - Mortalidad 1 año : 30%
  - Moritalidad 2 años : 40%
- Pacientes con ascites deben ser considerados para trasplante hepático :

Recommendation	Grade of evidence	Grade of recommendation
Since the development of grade 2 or 3 ascites in patients with cirrhosis is associated with reduced survival, LT should be considered as a potential treatment option	II-2	1

- Lamentablemente muchos pacientes pueden tener scores de Meld bajos que no les da una adecuada priorización en la lista de TX.

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Manejo de ascites grado 3

- **Grado 3** o ascites severa
  - Paracentesis evacuadora masiva es el tratamiento de elección
    - La ascites debe ser removida idealmente en una única sesion.*
  - Contraindicaciones :
    - Paciente no cooperador, infecciones de la piel en sitios de punción, embarazo, coagulopatia severa, distension intestinal severa.

Recommendation	Grade of evidence	Grade of recommendation
LVP should be **followed with plasma volume expansion**	I	1
Plasma volume expansion should be performed by **albumin infusion** (8 g/L ascites) • For >5 L of ascites: more effective than other plasma expanders • For <5 L of ascites (low risk of PPCD): treat with albumin due to concerns about use of alternative plasma expanders	I III	1 1
After LVP, patients should receive the **minimum dose of diuretics** necessary to prevent re-accumulation of ascites	I	1
When needed, LVP should be performed in patients with AKI or SBP	III	1

*Grade of evidence I, grade of recommendation 1
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Drogas contraindicadas en pacientes con ascitis

- Pacientes con cirrosis desc. y ascitis tienen riesgo elevado de deterioro de la función renal con diversos tipos de drogas.

Recommendation	Grade of evidence	Grade of recommendation
NSAIDs should not be used (high risk of developing further sodium retention, hyponatraemia, and AKI)	II-2	1
Angiotensin-converting enyzme inhibitors, angiotensin II antagonists, or α1-adrenergic receptor blockers should not generally be used (increased risk of renal impairment)	II-2	1
Aminoglycosides are discouraged (increased risk of AKI) • Reserved for patients with severe bacterial infections that cannot be treated with other antibiotics	II-2	1
Contrast media • In patients with preserved renal function: does not appear to be associated with increased risk of renal impairment • In patients with renal failure: insufficient data, cautious use and preventative measures recommended	II III	2 1

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Mensajes

- Paciente que debuta con ascitis debe tener una evaluación completa que incluye la punción diagnóstica (ascitis grado 2 – 3).
- Ascitis no complicada grado 2 puede ser manejada en forma ambulatoria.
- El inicio de diuréticos debe ser cuidadoso, en especial en pacientes con otras complicaciones de la cirrosis (hiponatremia, encefalopatía, etc).
- Al iniciar terapia diurética los pacientes requeriran control cada 72 horas para evaluar complicaciones de la terapia y ajustes de dosis.
- Ascitis a tensión requiere hospitalización y punción evacuadora idealmente masiva con reposición de albumina.

Bibliografía

2018 | **Topic:** Cirrhosis and complications

Management of patients with decompensated cirrhosis

The natural history of cirrhosis is characterised by an asymptomatic compensated phase followed by a decompensated phase, marked by the development of overt clinical signs, the most frequent of which are ascites, bleeding, encephalopathy, and jaundice. The following Clinical Practice Guidelines (CPGs) represent the first CPGs on the management of decompensated cirrhosis.

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