

Management of Acute Variceal Bleeding

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KEYWORDS

- Portal hypertension • Acute variceal bleeding • Cirrhosis • Endoscopic band ligation
- Endoscopy • Vasoactive therapy

KEY POINTS

- Recent changes in the management of acute variceal bleeding (AVB) have resulted in decreased mortality.
- A structured approach incorporating airway safety, volume resuscitation, vasoactive and antimicrobial pharmacotherapy, and early endoscopy minimizes morbidity and mortality in patients presenting with AVB.
- Presenting features that indicate a high risk of failing standard vasoactive and endoscopic therapy include Child C cirrhosis, active bleeding on index endoscopy, presence of infection, or a hepatic vein pressure gradient greater than 20 mm Hg.
- Patients at high risk of failing standard therapy for AVB may benefit from more aggressive approaches such as early TIPS placement following the index endoscopy.



Endoscopic Band Ligation (EBL) of esophageal varices accompanies the article at <http://www.liver.theclinics.com/>

INTRODUCTION

Acute variceal bleeding (AVB) remains one of the most dangerous complications of portal hypertension. Advances in the management of AVB have resulted in a decline in the rate of hospitalization in recent years,¹ and mortality has decreased from 50%² to between 15% and 20%^{3,4} over the last 3 decades. Despite these advances, in-hospital mortality remains high and is related to the severity of the underlying cirrhosis, ranging from 0% in Child A to 32% in Child C disease.⁵

A prompt and standardized approach to patients with variceal bleeding is required to minimize the risk of bleeding-related mortality. This integrated and multidisciplinary approach consists of airway protection, judicious volume resuscitation, vasoactive therapy, antibiotic prophylaxis, and endoscopic intervention (**Box 1**).

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Box 1**Approach to variceal bleeding***Airway management*

- Consider endotracheal intubation if:
 - Altered mental status
 - Massive hemorrhage requiring emergent endoscopy

Volume resuscitation

- Place 2 large-bore intravenous access catheters
- Avoid excessive volume replacement
- Maximum hemoglobin target of 7 to 8 g/dL
- Use of FFP or platelets to correct coagulopathy may not be beneficial

Vasoactive therapy

- Reduce portal pressure by using one of the following:
 - Octreotide: 50 µg IV bolus followed by 50 µg/h infusion
 - Terlipressin^a: 2 mg every 4 h IV for 24 to 48 h, then 1 mg every 4 h
 - Somatostatin^a: 250 µg IV bolus followed by 250 to 500 µg/h infusion
 - Vasopressin: 0.4 units/min IV plus IV or transdermal nitroglycerin
 - Vapreotide^a: IV bolus of 50 µg followed by 50 µg/h infusion

Antibiotic prophylaxis

- Initiate antibiotics to reduce rebleeding risk; choose either:
 - Ceftriaxone 1 g IV every day for up to 7 days
 - Norfloxacin 400 mg orally once a day for up to 7 days

Endoscopic therapy

- Obliterate varices using band ligation

Abbreviations: FFP, fresh frozen plasma; IV, intravenous.

^a Not currently available in the United States.

AIRWAY MANAGEMENT

Most patients presenting with AVB are alert, not massively bleeding, and have an intact gag reflex. In this situation, no special precautions are needed to protect the airway.⁶ Patients presenting with altered mental status, often caused by hepatic encephalopathy or intoxication, are at risk of aspiration and a decision to protect the airway via endotracheal intubation should be made early in the course. Patients with massive gastrointestinal bleeding not responding to initial interventions and in need of emergent endoscopic therapy are at high risk for aspiration and should undergo endotracheal intubation before sedation and endoscopy regardless of their mental status.⁷

VOLUME RESUSCITATION

At least 2 large-bore (14–18 gauge) venous accesses should be placed on admission for rapid administration of fluids and blood products. Excessive volume replacement may lead to increased portal pressure and increases the risk for early rebleeding from

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