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## REVIEW

# An update on the management of acute esophageal variceal bleeding

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### KEYWORDS

Acute variceal haemorrhage;  
Treatment;  
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Endoscopic ligation;  
Early TIPS;  
Baveno VI recommendations

**Abstract** The mortality rate in acute variceal haemorrhage remains high (around 15%). Treatment is based on the combined use of vasoactive drugs, endoscopic band ligation, and prophylactic antibiotics. Effective resuscitation (haemostasis, volume management) is essential to prevent complications. Treatment failure is best managed by transjugular intrahepatic portosystemic shunt (TIPS). Balloon tamponade or specifically designed covered oesophageal stents can be used as a bridge to definitive therapy in unstable patients. Early, pre-emptive TIPS should be the first choice in patients at high risk of treatment failure (Child-Pugh B with active bleeding or Child-Pugh C < 14). This article reviews the most recent advances in the management of variceal bleeding and discusses the recent recommendations of the Baveno VI consensus conference.

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### PALABRAS CLAVE

Hemorragia aguda por varices;  
Tratamiento;  
Fármacos vasoactivos;  
Ligadura endoscópica;  
Uso precoz de derivación portosistémica;  
Recomendaciones Baveno VI

### Una actualización sobre el manejo de la hemorragia aguda de várices esofágicas

**Resumen** La hemorragia aguda por varices continúa presentando una alta tasa de mortalidad (alrededor de un 15%). Su tratamiento se basa en el uso combinado de fármacos vasoactivos y tratamiento endoscópico mediante ligadura, junto a profilaxis antibiótica. El uso de medidas de reanimación efectivas (hemostasia, corrección de volumen) resulta esencial con objeto de prevenir las complicaciones. En caso de fallos del tratamiento, se debe realizar una derivación portosistémica percutánea intrahepática (DPPI o TIPS). En pacientes inestables, el taponamiento esofágico con balón o el empleo de prótesis (stent) esofágicas recubiertas pueden utilizarse como una medida transitoria hasta la realización del tratamiento definitivo. La utilización precoz de TIPS debe ser de primera elección en pacientes de alto riesgo de fallos del tratamiento (Child-Pugh B con sangrado activo o Child-Pugh C < 14 puntos). En este artículo se revisan los avances más recientes en el manejo del sangrado por varices y se discute las últimas recomendaciones de la VI conferencia de consenso de Baveno.

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## Introduction

Acute variceal bleeding (AVB) accounts for 70% of all upper gastrointestinal bleeding episodes in cirrhosis.<sup>1,2</sup> Several advances in the treatment of these patients have been made in the last decades, mainly the introduction of endoscopic therapies (initially sclerotherapy and subsequently endoscopic variceal ligation and glue injection), pharmacological therapy (vasopressin, somatostatin and their analogues) and transjugular intrahepatic portal systemic shunt. The improvement in hemostatic treatments and in the general management has resulted in a major decrease in mortality, from around 40% in the 1980s<sup>3</sup> to 15–20% in early 2000s.<sup>4</sup> However, even in the last published series it remains above 15%<sup>5</sup> which places this complication as one of the most serious of medical emergencies. Acute variceal bleeding is no longer the main cause of mortality in these patients. Nowadays most deaths are related to deterioration in liver or kidney function, or due to infections.<sup>4,5</sup> Thus, therapy needs to focus not only in bleeding control, but also in protecting the liver, prevent acute kidney injury and preventing infections.<sup>6</sup>

The major determinants of mortality are baseline liver and kidney function. Thus, not unexpectedly, the best predictor of mortality is the MELD score (which includes INR, Bilirubin and creatinine).<sup>5</sup> A MELD score >19 points is associated with >20% mortality, whereas a MELD score <11 points is associated with a mortality risk <5%.<sup>5</sup> This might serve to stratify a patient's care. Patients at high-risk should be managed in an intensive care setting by a team of experienced medical staff, including well-trained nurses, clinical hepatologists, endoscopists and interventional radiologists. Lack of these facilities requires immediate referral. A standardized set of orders can optimize adherence to guideline based care.<sup>7</sup> Initial therapy should aim at hemodynamic resuscitation, initiation of vasoconstrictor therapy, antibiotics and endoscopic therapy (Fig. 1).

## General management

The general management of the bleeding patient is aimed at correcting hypovolemic shock (with judicious volume replacement and transfusion) and at preventing complications associated with gastrointestinal bleeding (bacterial infections, hepatic decompensation and renal failure).<sup>8</sup>

### Blood volume replacement and transfusion

Blood volume replacement should be initiated as soon as possible with plasma volume expanders, aiming to maintain the systolic blood pressure around 100 mmHg. A rapid correction of hypovolemia is particularly important to reduce the risk of renal failure and impaired hepatic perfusion. Although in the past it was recommended to maintain these patients in relative hypovolemia (since reflex splanchnic vasoconstriction induced by hypovolemia would decrease portal pressure and in that way improve the control of bleeding), this was not evidence-based and it is probably harmful due to the risk of complications. In addition, it needs to be taken into account that nowadays haemostatic therapies are highly effective, and most deaths are not related to ongoing bleeding, but to the complications that could be associated with hypovolemia.

Blood transfusion strategy (which is differentiated from volume replacement), deserves special consideration. A recent large randomized trial in patients with acute upper gastrointestinal bleeding showed that a restrictive transfusion policy, using a Hb threshold for transfusion of 7 g/dL, improves survival, as compared with a more liberal strategy (Hb threshold of 9 g/dL).<sup>9</sup> These results were also verified in the subgroup of patients with cirrhosis and acute variceal bleeding. It is important to note that all patients received adequate and similar volume resuscitation before blood

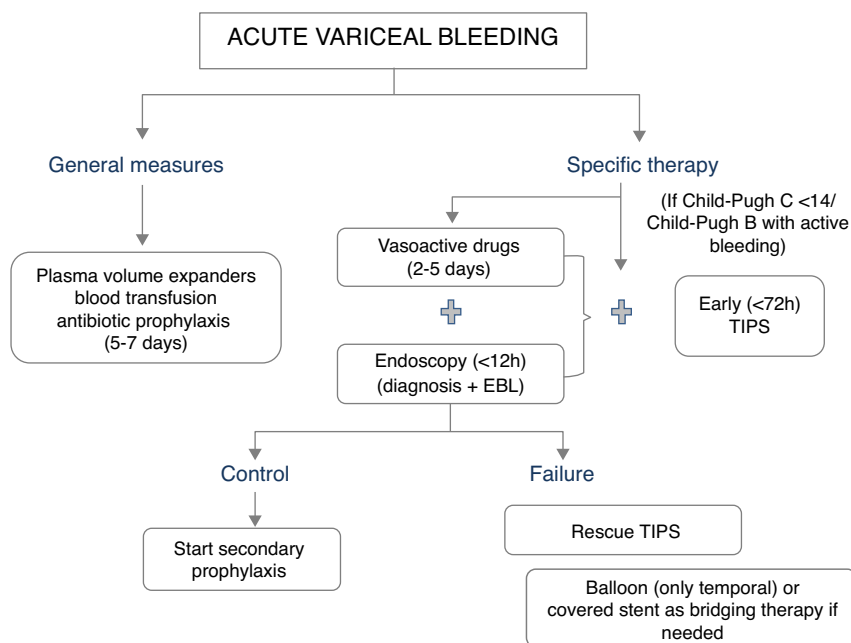


Figure 1 Summary of the management of acute variceal bleeding.

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