Bleeding varices treatment guidelines

This website uses cookies. By continuing to use this website, you consent to the use of cookies. For information about cookies and how to disable them, visit our privacy and cookie policy. I got it, thank you! These updated guidelines for the management of varicose bleeding have been ordered by the Clinical Services and Standards Committee (CSSC) of the British Society of Gastroenterology (BSG) under the auspices of the liver section of BSG. The original guidelines that replaced the document were written in 2000 and were scrutinized by 13 members of the Guidelines Development Group (GDG). GDG includes elected members of the BSG liver section, a representative from the British Association for the Study of The Liver (BASL) and Liver KeST, a representative of the nurses and a patient representative. The quality of the evidence and the evaluation of recommendations were evaluated using the AGREE II tool. These guidelines specifically relate to the treatment of varicose varicose liver in the following subtitles: (1) primary prevention; (2) acute varicose bleeding; (3) secondary prevention of varicose bleeding; and (4) gastric varicosees. They are not designed to combat (1) management of underlying liver disease; (2) management of varicose bleeding in children; or (3) varicose bleeding from other etiological conditions. Risk FactorsIn the International Normalized Ratio (INR) score of zgt;1.5, the portal veins with a diameter of 13 mm, and thrombocytopenia have been found to predict the probability of varicose veins present in cirrhotics. If none, one, two, or all three of these conditions are met, 90% of patients are estimated to have varicose veins, respectively. The presence of one or more of these conditions is a sign of endoscopy to search for varicose varicose varicose varicose process and primary prevention of bleeding in patients with cirrhotics (see table below). Table: Risk Factors for Esophageal Variances and Hemorrhage Development Of High Portal Vein Pressure: Hepatic venous Pressure Gradient (HVPG) Art. in patients, who do not have varicose initial endoscopic screening progression from small to large varicose decompensated cirrhosis (Child-Pugh B/C) Alcoholic cirrhosis The presence of red gross marks on the base endoscopy (longitudinal enlarged veins on Varicose Marks on varicose Surface) Initial Varicose Bleeding Episode Large Varicose (5 mm) with red colored marks High Child-Turcotte-Pugh (CTP) or Model for End Stages of Liver Disease (MELD) Score Continuing Continuing Continuing Alcohol High HVPG zgt;16 mmHg Coagulopathy Diagnostics and differential diagnosisEsophagogastroodenoscopy (EGD) is the gold standard for esophageal diagnosis of zlt;10%, qgt; If the gold standard is unavailable, other possible diagnostic steps will be Doppler's ultrasonography of circulation (non-endoscopic ultrasonography). While this is a poor second choice, it can certainly demonstrate the presence of varicose. Other alternatives include radiography/barium swallowing of the esophagus and stomach, as well as portal vein angiography and gauge. It is important to assess the location (oesophagus or stomach) and the size of varicose varicose varicose varicose varicose veins, signs of imminent, first acute or recurrent bleeding, and (if applicable) consider the cause and severity of liver disease. Table: Guide to diagnosing esophageal varicose 1 Screening esophagogastroduodenoscopy (EGD) for the diagnosis of oesophagus and gastric varicose varicose varicose varicose is recommended when a diagnosis of cirrhosis of the liver has been made 2 endoscopy observations recommended based on the level of cirrhosis of the liver and the presence and size of va Ricos: Patients with and repeat EGD Compensated Cirrhosis of the Liver No varicose growth Every 2-3 years Small varicose every 1-2 years Decompensated cirrhosis year 3 Gastrointestinal varicose muscle progression can be determined based on the classification of size during EGD. In practice, the recommendations for the average varicose varicose in the three-dimensional classification are the same, as for large varicose in two-dimensional classification: the size of the varix two-size-5 mm minimally elevated veins above the esophageal' mucosal surface q medium'-tortuous veins' occupying less than one-thirds of the esophageal lumen occupying more than one-third of the esophagus 4 Varise hemorrhage is diagnosed based on one of the following findings on endoscopy: Active bleeding from the varix White nipple excessive varix clots excessive variks varisk without any another potential source of bleeding Differential diagnosis of varicose varisa /hemorrhage Differential diagnosis of varicose hemorrhage (VH) includes all etiology (upper) gastrointestinal bleeding. Ulcers are also more common in cirrhotics. Table: Differential diagnosis of esophageal variations/bleeding Sistosomiasis Severe congestive heart failure Hemochromatosis Wilson's Disease Autoimmune Hepatitis Portal/Splenic vein thrombosis Sarcoidosis Budd-Chiari chronic pancreatic syndrome Hepatitis C Hepatitis C Alcoholic cirrhosis of primary bile cirrhosis (PBC) Primary sclerosing cholangitis (PSC) Note: All this leads to the development of varicose varicose varicose varicose development as a result of portal hypertension. Other ConsiderationsTable: Consideration in the diagnosis, prevention and management of varicose varisa and varicose hemorrhage screening Esophagogastroduodenoscopy (EGD) in cirrhotic The presence of high-quality varicose novoagres or red traces of the shaft may be an indication for the preventive banding many who undergo EGD screening do qgt;/5 qgt; qgt; qgt; qgt; have varicose varicose preparations or do not require preventive therapy Expensive; I need to avoid sedation in patients with cirrhotics with non-selective β-blocker for hypertension or for other reasons of non-invasive markers - for example, Platelets Graf, FibroTest, Spleen Size, Portal Vein Diameter, Transitional Elastography Predictive Precision is still unsatisfactory β-blocker therapy Economically effective form of preventive therapy does not prevent the development or growth of small to large varicose has significant side effects Patients receive selective β-blocker (costhorolol , atenolol) for other reasons should go to non-selective β The following treatment options are available in the management of varicose varicose and hemorrhage (see tables below for pharmacological therapy and endoscopic therapy). Although they are effective in stopping bleeding, none of these measures, with the exception of endoscopic therapy, have been shown to affect mortality. Table: Pharmacological Therapy Plannik Vasopressin (similar) Somatostatin (similar) Non-pedagogue β-blockers Pharmacotherapy with somatostatin (similar) is effective in stopping hemorrhage, at least temporarily, in up to 80% of patients. Somatostatin can surpass analog octreotide. About 30% of patients do not respond to β-blockers with a reduction in venous gradient of venous pressure (HVPG), despite adequate dosing. These non-responders can only be detected by invasive HVPG measurements. In addition, β blockers can cause side effects such as fatigue and impotence, which can impair compliance (especially in young men), or β blockers may be contraindicated for other reasons. Nitrates is not recommended by itself. Isosorbide 5-mononitrate (ISMN) reduces the pressure of the portal, but its use in patients with cirrhotics is limited by its systemic vasodilator effects, often leads to a further reduction in blood pressure and potentially (pre-diagnosed) impaired kidney function. Vasocyanating agents and vasodilator combination therapy leads to a synergistic effect of reducing the pressure of the portal. The combination of ISMN with non-selective β blockers has been shown to have additive effects in reducing portal pressure and is particularly effective in patients who do not respond to initial therapy only β blockers. However, these beneficial effects may be outweighed by the detrimental effects on kidney function and long-term mortality, especially in those over the age of 50. Therefore, regular use of combination therapy is not recommended. The use of vasoactive drugs can be safe and effective whenever endoscopic therapy is not quickly and is associated with less adverse events than emergency sclerotherapy. Table: Endoscopic Therapy Local Therapy Endoscopic Varicose Dressing (EVL) or Sclerotherapy Sclerotherapy Effect on portal flow or resistance Shunting therapy surgical or radiation (transuular intraheptic portosystemic shunt TIPS) reduces the pressure of portal endoscopic sclerology and varicose band dressings are effective in stopping bleeding in up to 90% of patients. EVL is more effective than endoscopic varicose sclerotherapy (EVS) with greater hemorrhage control, lower bleeding, and lower adverse events, but no differences in mortality. However, endoscopic band dressing may be more difficult to apply than sclerotherapy in patients with severe active bleeding. Transjugulatory intraceptual port-system shunt (TIPS) is a good alternative when endoscopic treatment and pharmacotherapy fail. The use of a balloon tamponade decreases as there is a high risk of bleeding after deflation and the risk of serious complications. However, balloon tamponade is effective in most cases in stopping hemorrhage at least temporarily, and it can be used in regions of the world where EGD and TIPS are not readily available. This can help stabilize the patient in order to gain time and access to EGD and/or TIPS later.Combined endoscopic and pharmacological treatments are shown to achieve better control of acute bleeding than endoscopic treatment alone. Clinical Practice Approach in patients with cirrhosis of the liver and various stages of varicose varicose bleeding is shown in the following drawings. Illustration: Patients with cirrhosis of the liver, but without varis. No varicose β-blockers prevent varicose enlargement - o Repeat esophagogastroodenoscopy (EGD) in 3 years - o Immediate EGD if hepatic decompensation occurs Figure: Patients with liver cirrhosis and small varices, But no hemorrhage Increased risk of hemorrhage: B/C Marks o Non-selective β blockers to prevent the first varicose hemorrhage No increased risk - o β blockers can be used - long-term benefits are not set Not to receive β-blockers - o Repeat esophagogastroduodenoscopy (EGD) in 2 years - o In the case of liver depensation: EGD at once; Because many β patients do not respond to β-blocker treatment or bleeding prevention, it is recommended that EGD be repeated after 2 years (as for those who do not receive β blockers). Drawing: Patients with cirrhosis of the liver and medium or large varisa, but without hemorrhage. High risk of hemorrhage: Baby B/C or varicose red shaft marking No-o β-blockers (propranolol, nadol, or frenolog) or endoscopic varicose dressing (EVL) is recommended for the prevention of the first varicose hemorrhage not on the High risk: Child patients and no β red signs of nadolol, or carvedilol) preferably - o In the case of contraindications, intolerances, non-compliance: consider EVL non-cardiocelective β-blockers (propranolol, nadolol, or or or or Starting with a low dose, if necessary, increasing the dose step by step until a reduction in the heart rate of rest is achieved by 25%, but not below 55 beats/min. Compared to β blockers it has been found that EVL significantly reduces episodes of bleeding and severe side effects, but this does not affect the mortality rate. Figure: Patients with cirrhosis of the liver and acute varicose hemorrhage EMERGENCY SCHEME, if varicose hemorrhage is suspected in the next 12-24 hours - 1/4 - 1/4 Resuscitation measures intravenously (IV) the amount of blood transfusion support Antibiotic prophylactic prevention (up to 7 days) norfloxacin (400 mg BID) or IV ciprofloxacin or IV ceftriaxone (1 g/day) with progression of cirrhosis pharmacological therapy - Continue 2-5 days after confirmed diagnosis of tyrlypressin (2 mg every 4 hours) or somatostatin (or octreotide, octreotide, Vapreotide) Within 12 hours: Confirm diagnosis with esophagogastrodudoscopy (EGD) Treat varicose hemorrhage with endoscopic varicose dressing (EVL) or sclerotherapy Uncontrolled bleeding or relapse: The Transhugulic Intracular Portosystemic Shunt (TIPS) is indicated in uncontrolled bleeding while waiting for TIPS or endoscopic therapy : Terlipressin is currently available in much of Europe, India, Australia and the United Arab Emirates but not in the United States or Canada.Acute varicose hemorrhage is often associated with bacterial infection due to bowel translocation and impaired mobility. Preventive antibiotic therapy has been shown to reduce bacterial infections, varicose bleeding and increase survival. In acute or mass varicose bleeding, tracheal intubation can be extremely useful to avoid the

bronchial urge of blood. In patients with VH in the gastric foundation: endoscopic varicose obliteration using tissue adhesives (such as cyanoaccrylate) is preferred; second choice of EVL. TIPS should be considered in uncontrolled financing of bleeding or relapse, despite combined pharmacological and endoscopic therapy. Emergency sclerotherapy is no better than pharmacological therapy in acute varicose bleeding in cirrhosis of the liver. Terlipressin reduces the inability to control bleeding and mortality, and should be the first choice for pharmacological therapy when needed. Where terlipressin is not available, somatostatin, octreotide and vapreotide can be used. Treatment of oesophageal bleeding with analogues of somatostatin does not appear to reduce mortality, but may reduce the need for blood transfusions. Figure: Patients with cirrhosis of the liver who have recovered from acute varicose hemorrhage Secondary Prevention No-o Non-selective β blockers plus endoscopic varicose dressings (EVL) - o Adjust the β blocker to the maximum - o Repeat EVL every 1-2 weeks prior to obsesophagealization (EGD) in 1-3 months in children A/B patients with recurrent hemorrhage Combination Therapy No-o Consider Surgical Bypass in Child Patients - o Contact the TransplantAtion Center to evaluate long-term endoscopic control and banding or sclerotherapy of recurrent varicose varicose process every 3 to 6 months (in many places in developing countries, only sclerotherapy will be available). If endoscopic band dressing is inaccessible or contraindicated, non-cardioceselic β blockers (proranolol, nadol or fresnolole), starting with a low dose and, if necessary, increasing the dosage step by step, Until a 25% reduction in heart rate has been achieved, but not below 55 strokes/min. In younger patients with less advanced liver cirrhosis (Child-Pugh A), the addition of isosorbide 5-mononitrate (ISMN) (starting at 2 × 20 mg per day and increase to 2 × 40 mg per day) may be considered if sclerotherapy or pharmatherapy fails. TIPS should be taken into account, especially in applicants for liver transplantation. In some cases (patients with well-preserved liver function, stable liver disease), you can consider a calibrated H-graft or a dystal splenorenal shunt (Warren shunt). Portosystem bypasses are associated with lower rates of varicose bleeding compared to sclerotherapy/banding, but they increase the incidence of hepatic encephalopathy. Liver transplantation should always be considered if the patient has a child-Pugh B grade or C. Recommendations for the first line of management of cirrhotic patients at each stage of the natural history of variations (see. Figure below)Figure: Recommendations for first line of control No Varices Repeat endoscopy in 2-3 years No 1/4 Small Varitsa - No hemorrhage Repeat endoscopy in 1-2 years - 1/4 Medium / Big Varis - No hemorrhage β blockers (propranolol, polisol, Endoscopic varicose dressing (EVL) if β blockers are not allowed No. 1/4 Varise hemorrhage Specific therapy: safe vasoactive drug Recurring hemorrhage β Non-mononitrate (ISMN) or EVL β blockers - CASCADE EVL for the TreatmentA cascade is a hierarchical set of diagnostic or therapeutic methods for the same disease ranked by available resources. As mentioned above, several therapeutic options are effective in most clinical situations involving acute varicose hemorrhage, as well as in secondary and primary prevention against it. Optimal individual therapy largely depends on the relative simplicity of local availability of these methods and methods. This is likely to vary widely in different parts of the world. If endoscopy is not always available, you should resort to pharmacotherapy in any case of suspected varicose bleeding - for example, in patients with and signs of cirrhosis of the liver. Similarly, pharmacological therapy can be introduced in circumstances such as primary prevention in cirrhotic patients with signs of portal hypertension hypertension thrombocytopenia) and/or liver dysfunction, as well as secondary prevention in cirrhotic patients with a history of upper gastrointestinal bleeding. If pharmacotherapy is also inaccessible and it is suspected of varicose bleeding, it is necessary to resort to general resuscitation measures and as soon as possible to bring the patient to an institution where the necessary diagnostic/therapeutic means are available; a tamponade of a balloon can be extremely useful in such a situation. Figure: Cascade for the treatment of acute esophageal varicose hemorrhage Resource level Gold Standard - Band dressing - vasoactive intravenous (IV) drug therapy: octreotid or terlipressin - 1/4 Normal - Band dressing -1/4 Medium - Sclerotherapy No 1/4 Low - Balloon Therapy Note: Combination of bandages except when the bleeding is too extensive for the vessel to be identified for banding. In such cases, sclerotherapy can be performed in order to control the bleeding and clear the field enough for the banding to do afterwards. Warning: There are many conditions that can lead to varicose esophagus. There are also many treatment options, depending on the resources available. For example, for the approach to treatment using resources in Africa, Sudan, varicose varicose varicosis treatment Fedail SS. Esophageal. Gastrointest Endosc 2002;56:781-2 can be consulted. Consultation. esophageal varices bleeding treatment guidelines