Baveno Consensus & this case

Dr Neil Lachlan

Consultant Hepatologist

Glasgow Royal Infirmary

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Baveno VII – Renewing consensus in portal hypertension*

- Interested practitioners, have been meeting every so often since the 80s to discuss PHT including diagnosis, management and research.
- Most recent consensus, like everything else, was delayed by Covid-19
- Title of Baveno VII workshop “Personalized Care for Portal Hypertension”
- 9 main topics with consensus statements published

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Lots going on in this case

- Previous resection for HCC, then new lesions develop
- Portal vein thrombosis
- Gastric variceal bleed
- Terlipressin complication
- BRTO or TIPS – patient and IR dependant factors
- Good outcome for this chap (for now..)

Consensus state

- Compensatec
  which reflect
- Heavy lean tc
  - LSE <20KpA
  - Rule of 5s
- Personalised
  - Need to ass
  - Our patient
    - Rise in L
    - Fall in p
    - Decision taken to commence NSBB when PV Thrombosis occurred

2) Non-invasive tools for cACLD and portal hypertension

Definition of cACLD

2.1 The use of elastography in clinical practice has enabled the early identification of patients with untreated/active chronic liver disease at risk of having CSPH and consequently, at risk of decompensation and liver-related death. **(A.1) (Changed)**

2.2 The term "compensated advanced chronic liver disease (cACLD)" had been proposed to reflect the continuum of severe fibrosis and cirrhosis in patients with ongoing chronic liver disease. A pragmatic definition of cACLD based on liver stiffness measurement (LSM) is aimed at stratifying the risk of CSPH and decompensation at point of care, irrespective of histological stage or the ability of LSM to identify these stages. **(B.1) (Changed)**

2.3 Currently, both terms "cACLD" and "compensated cirrhosis" are acceptable, but not interchangeable. **(B.1) (Changed)**

osed term
hosis in CLD

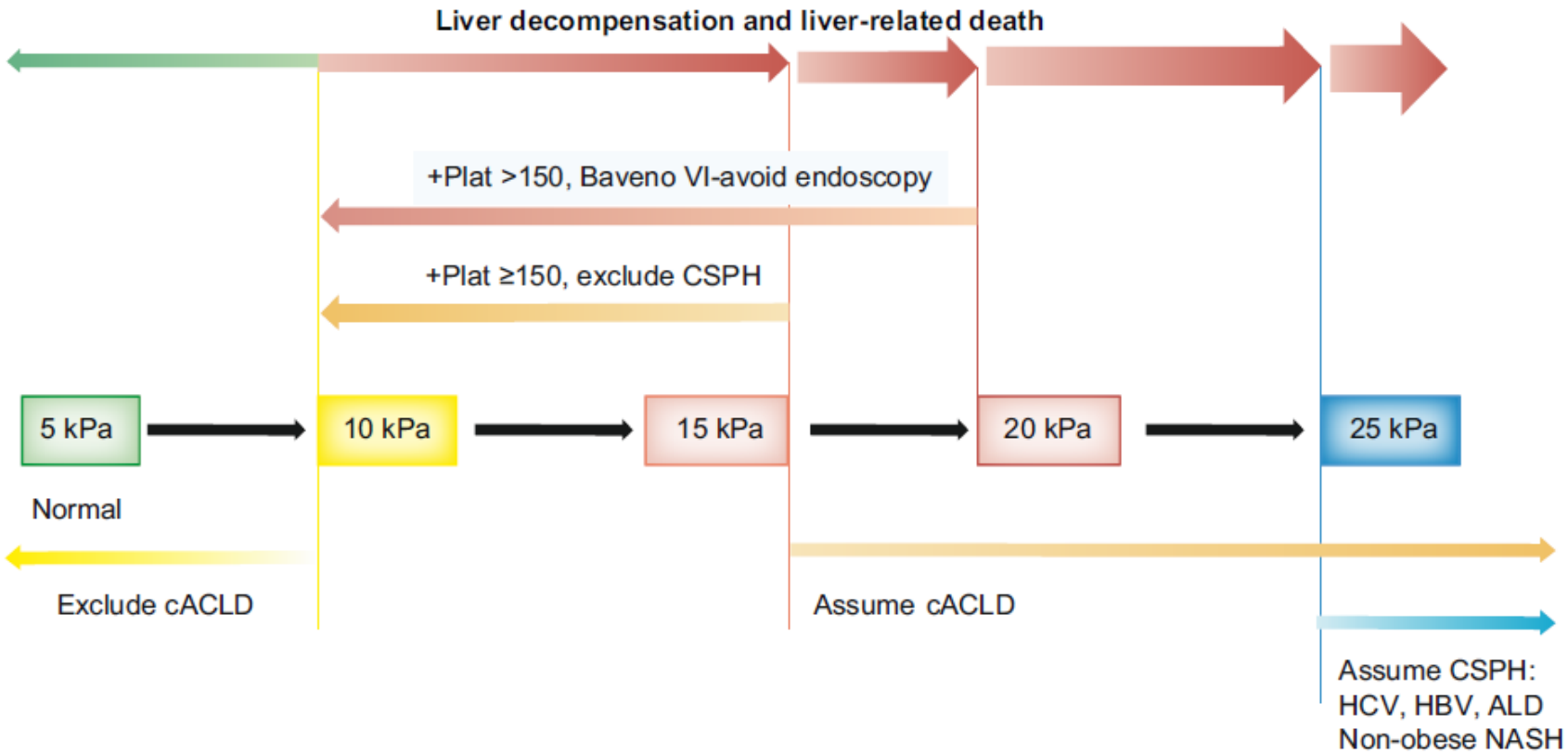


Fig. 1. Algorithm for the non-invasive determination of cACLD and CSPH. ALD, alcohol-related liver disease; cACLD, compensated advanced chronic liver disease; CSPH, clinically significant portal hypertension; NASH, non-alcoholic steatohepatitis.

6.5 In suspected variceal bleeding, vasoactive drugs (terlipressin, somatostatin, octreotide) should be started as soon as possible and continued for 2-5 days. **(A.1) (Changed)**

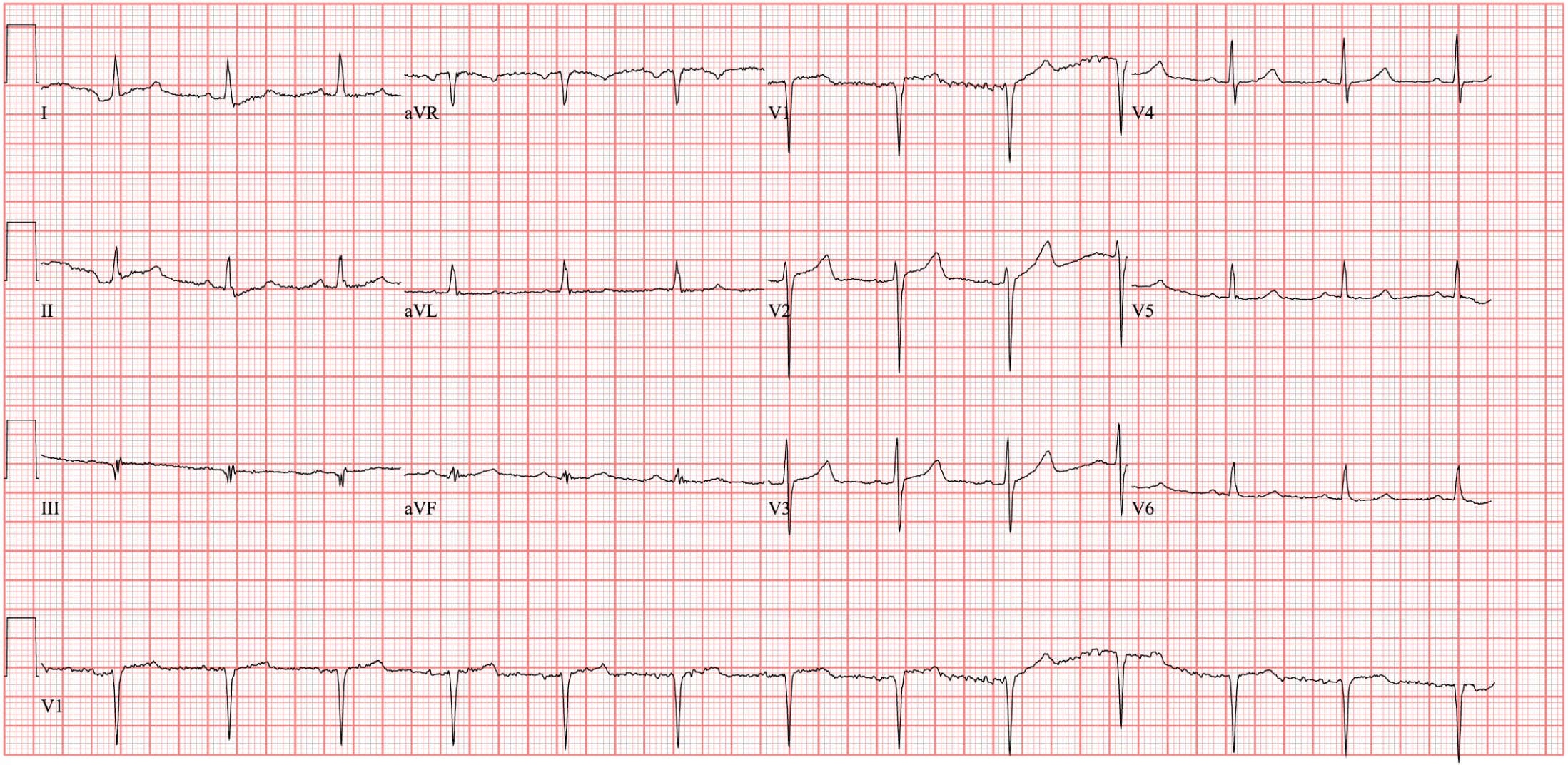
Terlipressin

- Fluid resuscitate the patient first
- Powerful drug that acutely drops portal pressure
- More likely to control the bleeding episode

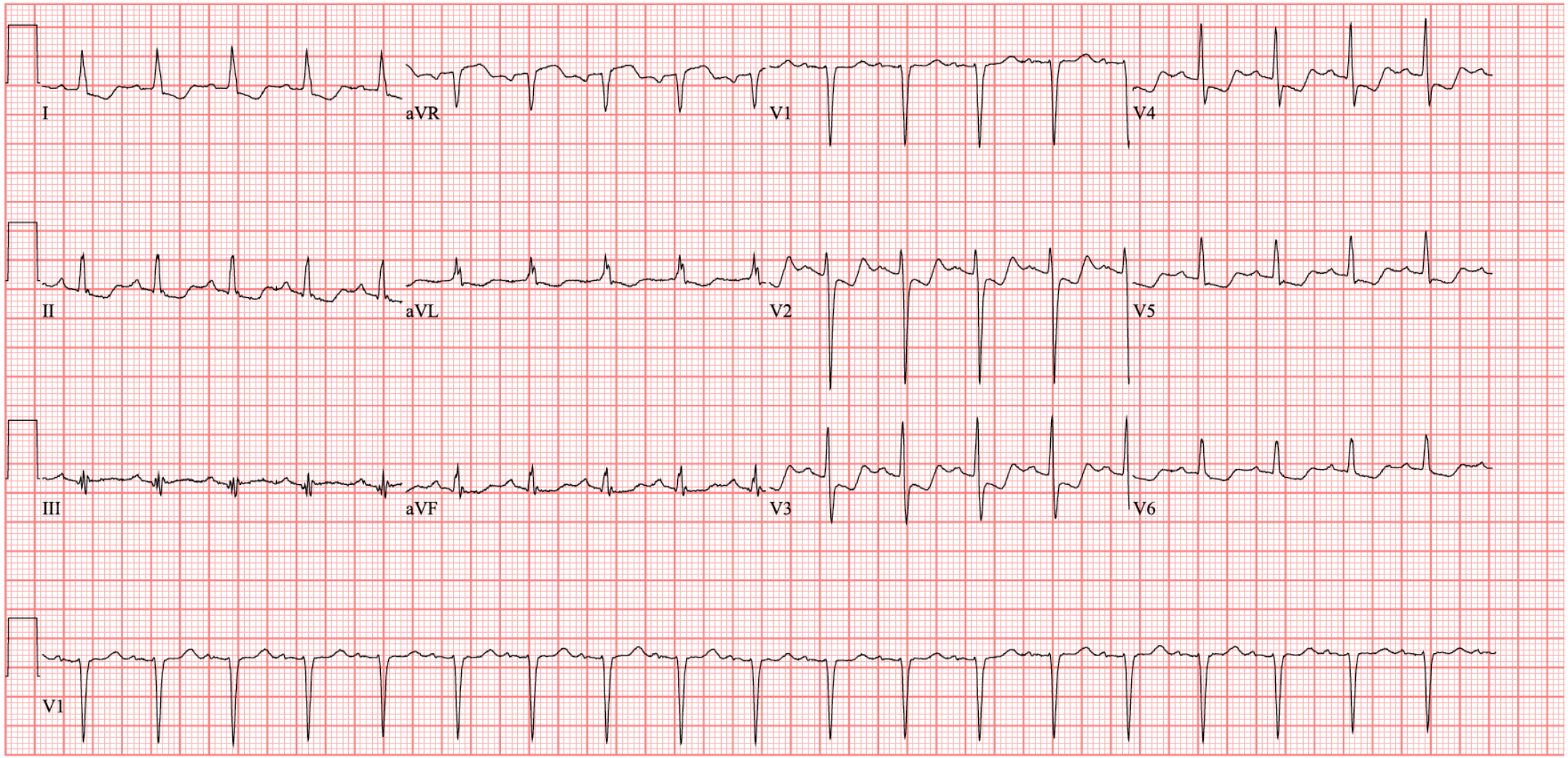
- But complications of terlipressin are seen frequently
  - Abdominal pain and diarrhoea
  - Myocardial ischaemia, AF

- OLT had previously been considered for our patient but his cardiovascular disease was significant

ECG in ED



ECG in HDU



6.2 Packed red blood cell transfusions should be performed conservatively, with a target haemoglobin level between 7-8 g/dl, although transfusion policy in individual patients should also consider other factors such as cardiovascular disorders, age, haemodynamic status and ongoing bleeding. **(A.1) (Unchanged)**

Blood products

- Real life case
- Our patient did receive from ED
  - 2 units blood (Hb was 118)
  - and 2 pools platelets (plt 89)

9.5 Anticoagulation is recommended in patients with cirrhosis and (i) recent (<6 months) completely or partially occlusive (>50%) thrombosis of the portal vein trunk with or without extension to the superior mesenteric vein, or (ii) symptomatic PVT, independently of the extension, or (iii) PVT in potential candidates for liver transplantation, independently of the degree of occlusion and extension. (**C.2**) (**New**)

Portal vein thrombosis

- Carvedilol and anticoagulation were started at PVT diagnosis
- Then he bleeds
  - But, we were very keen to re-anticoagulate asap
  - In our view he bled in spite of anticoagulation (not because of it)

- BRTO not TIPS – IR decision

Discussion/Questions