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Summary

Pre-intervention lab work: What every gastroenterologist should know for cirrhotics

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Hepatobiliary

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The speaker presented a practical framework for managing bleeding risk in cirrhotic patients undergoing invasive procedures, emphasizing that procedure type and clinical context outrank routine laboratory values in predicting bleeding complications.

KEY POINTS

- In a multicenter study of over 1000 patients and 3000 procedures, the speaker reported that any bleeding event did not occur in 97% and major bleeding did not occur in 99%, with the procedure itself (odds ratio 4.6), MELD score, and BMI predicting bleeding rather than pre-procedure INR, platelet count, or antithrombotic drug use
- The speaker stated that for low-risk procedures including diagnostic paracentesis, ERCP without sphincterotomy, and transjugular liver biopsy, routine correction of INR, PTT, or platelets above 30,000 per liter is not indicated
- For high-risk procedures such as sphincterotomy and large polyp resection, the speaker recommended considering platelet transfusion only when counts fall below 50,000, particularly below 30,000
- The speaker advised stopping direct oral anticoagulants one day before low-risk procedures and two days before high-risk procedures, and stated that apixaban and edoxaban are currently favored in Child-Pugh B cirrhosis
- A randomized trial presented by the speaker showed that thromboelastography-guided transfusion in patients with INR above 1.5 and platelets below 50,000 reduced blood product use with very low bleeding rates (zero in the guided group versus one in 30 standard-care patients)

– The speaker recommended five practices to avoid: determining INR solely to clear stable patients, giving fresh frozen plasma to correct cirrhosis-associated INR elevations, routine platelet transfusion for low-risk procedures, assuming elevated INR means no thrombotic risk, and delaying urgent procedures for non-evidence-based laboratory targets

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