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Summary

Acting upstream in the pathophysiological cascade of ascites and managing recurrent ascites and its consequences: From TAPS to TIPS

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The speaker presented a pathophysiology-based approach to ascites management in cirrhosis, emphasizing aetiological treatment as the cornerstone to change natural history, while positioning diuretics, selective antibiotic prophylaxis, and long-term albumin as adjuncts in specific patient subgroups.

KEY POINTS

- The speaker stated that aetiological treatment (alcohol cessation, HCV cure, HBV suppression) in patients with ascites as the first decompensating event was associated with a 65% reduction in mortality risk and that approximately 30-35% of patients may achieve recompensation.
- Diuretics (starting with spironolactone 100 mg/day, adding furosemide if needed) control ascites but do not change mortality risk, according to the speaker.
- The speaker reported that primary SBP prophylaxis with norfloxacin may be considered only in very high-risk patients (ascitic fluid protein below 15 g/L with specific additional criteria, bilirubin 3 mg/dL or higher, or renal dysfunction), but noted declining efficacy due to quinolone resistance and that rifaximin is not an alternative.
- The speaker stated that long-term albumin (40 g twice weekly then weekly) improved survival and reduced complications in the ANSWER trial, but the MACHT trial showed no benefit; patients who may benefit are those with grade 2-3 ascites on high-dose diuretics where albumin significantly raises serum albumin and is used beyond two months.
- The speaker emphasized that measuring 24-hour urine sodium is clinically useful to assess ascites accumulation rate, guide diuretic dose adjustments, identify dietary non-compliance, and predict prognosis.

– The speaker stated that TIPS is very effective for recurrent or refractory ascites but may cause hepatic encephalopathy in a significant proportion of patients and that better studies are needed before it can be recommended as first-line therapy.

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