

Treatment of cirrhotic ascites

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Cirrhosis is the most common cause of ascites and accounts for almost 85% of all cases. It is the most common complication of cirrhosis, developing in approximately 50% of subjects with compensated cirrhosis over 10 years. After development of ascites only 50% of patients will survive for 2 to 5 years.

Successful treatment is dependent on accurate diagnosis of the cause of ascites.

Because sodium and water retention is the basic abnormality leading to ascites formation, restriction of sodium and water is extremely beneficial in controlling ascites.

First treatment of patients with cirrhosis and ascites consists of sodium restriction (88 mmol or 2 g Na per day) and diuretics (oral spironolactone and furosemide). Fluid restriction is not necessary unless serum sodium is less than 120-125 mmol/L). The recommended initial dose is spironolactone 100-200 mg/d and furosemide 20-40 mg/d. Usual maximum doses are 400 mg/d of spironolactone and 160 mg/d of furosemide. The recommended weight loss in patients without peripheral oedema is 300-500 g/d. There is no limit to the daily weight loss of patients who have massive oedema.

Tense ascites is severe ascites associated with marked abdominal distension producing abdominal discomfort interfering with normal activities and limiting quality of life. Its initial management is large-volume paracentesis. When more than 5 L are removed, intravenous albumin (8 g/L fluid removed) should be administered in order to avoid circulation problems. As large-volume paracentesis does not correct the underlying problem that led to ascites formation, salt restriction and diuretic therapy should be added to the treatment to avoid rapid reaccumulation of abdominal fluid.

About 90% of patients respond to medical therapy for ascites. Refractory ascites is defined as fluid overload that is unresponsive to sodium-restricted diet and high-dose diuretic treatment (diuretic-resistant) or when there is inability to reach the maximal dose of diuretics because of adverse effects (diuretic-intractable). It has a poor prognosis. In patients with refractory ascites serial therapeutic paracenteses may be performed. TIPS should be considered in patients who repeatedly fail large-volume paracentesis and have relatively preserved liver functions. Liver transplantation is the only modality that is associated with improved survival.

References

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