

# MÁSTER EN HEPATOLOGÍA

**UAM**  
Universidad Autónoma  
de Madrid

 Universidad  
de Alcalá

**Asignatura: Cirrosis II**

**“Prevención de la hemorragia variceal y otras  
consideraciones: Revisando Baveno VII”**

**Agustín Albillos**

Hospital Universitario Ramón y Cajal, IRYCIS,  
Universidad de Alcalá, CIBERehd, Madrid

## **Baveno VII**

- LSM (irrespective of the technique used for its measurement) holds prognostic information in cACLD, both at index investigation and during follow-up (A;1).
- A rule of five for LSM by TE (10-15-20-25 kPa) should be used to denote progressively higher relative risks of decompensation and liver-related death independently of the etiology of CLD (B;1).



# Baveno VI



**Baveno VII**  
CONSENSUS WORKSHOP  
PERSONALIZED CARE  
IN PORTAL HYPERTENSION  
VIRTUAL  
October 27-30, 2021  
PEDIATRIC RESEARCH MEETING  
Primary Proceedings of National  
Hemorrhage, Complications  
to the Development of Evidence-Based  
Approaches in Pediatrics  
October 31, 2021

Compensated Advanced Chronic Liver Disease  
(cACLD)

LIVER STIFFNESS



< 10 kPa

> 15 kPa

< 10 kPa

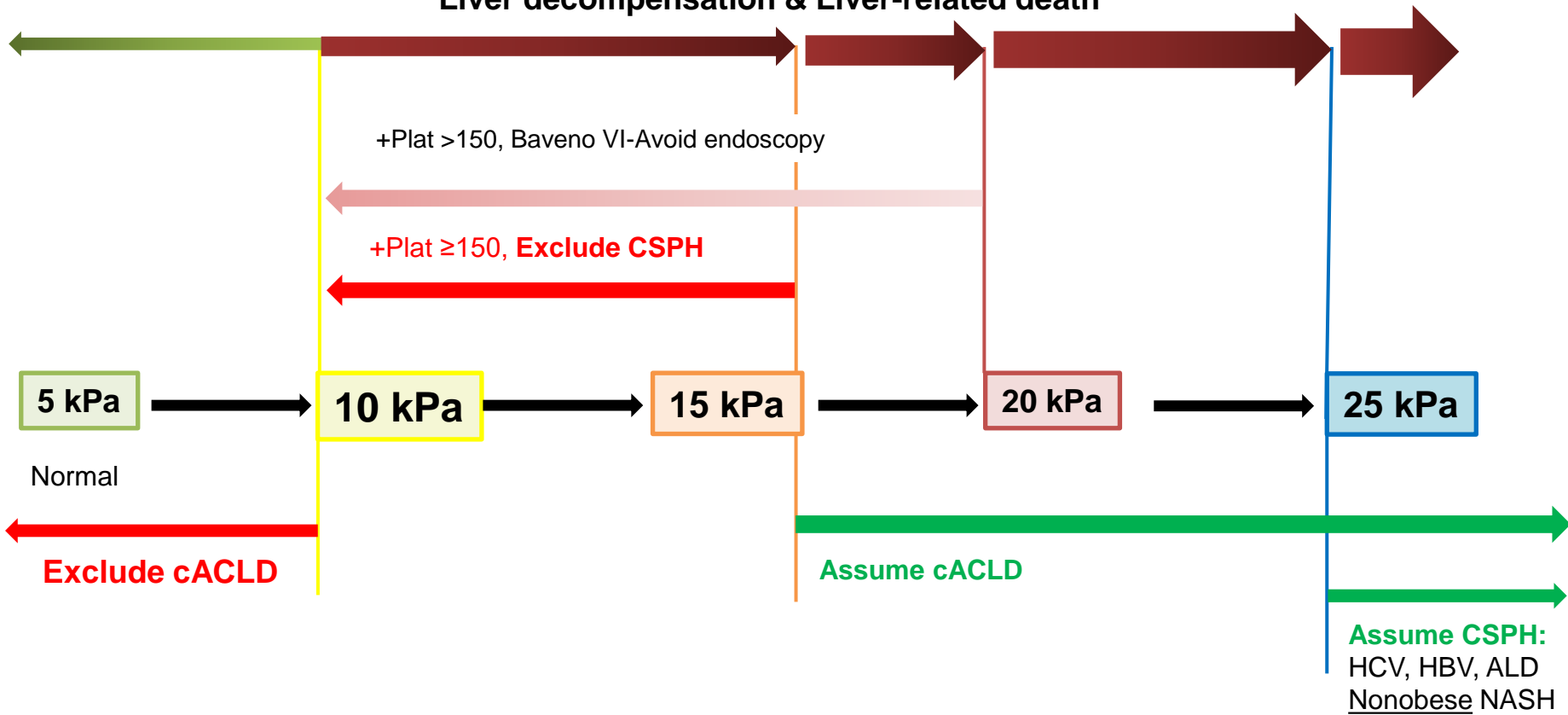
> 15 kPa

FIBROSIS STAGE  
(F3-F4)



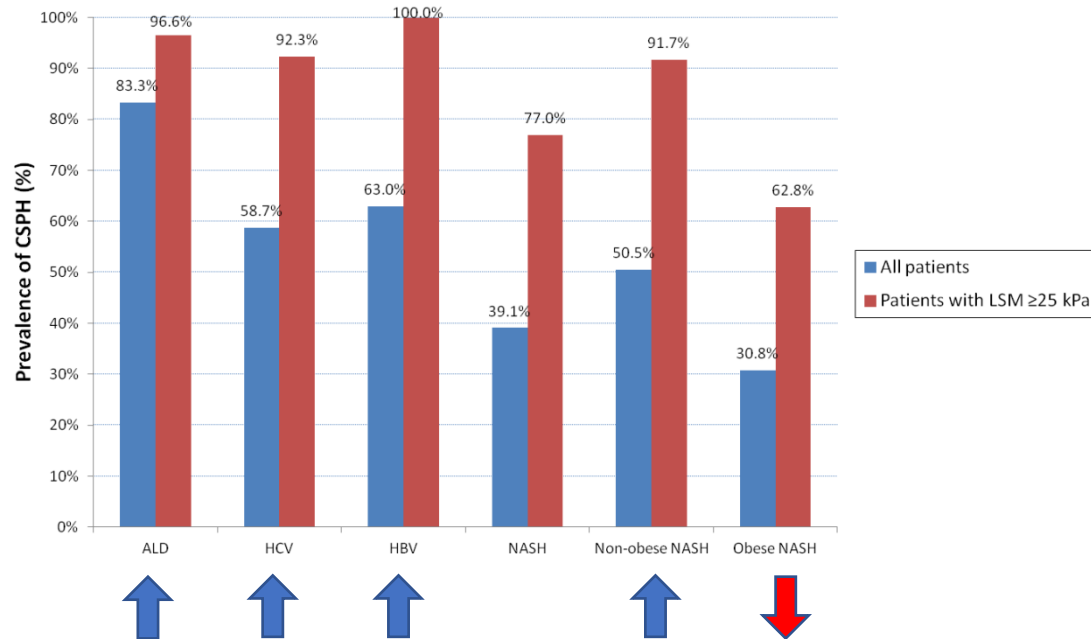
RISK OF LRE  
(DECOMP/L. DEATH)

## Liver decompensation & Liver-related death

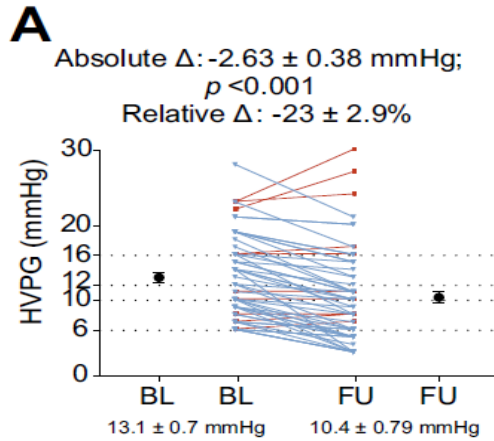


Non-invasive prediction in cACLD by TE-summary: THE RULE OF FIVE

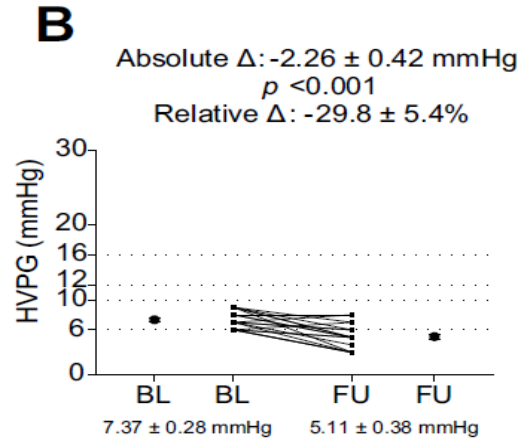
**LSM $\geq$ 25 kPa ruling in  
 (>90% PPV, >90% Sp)**



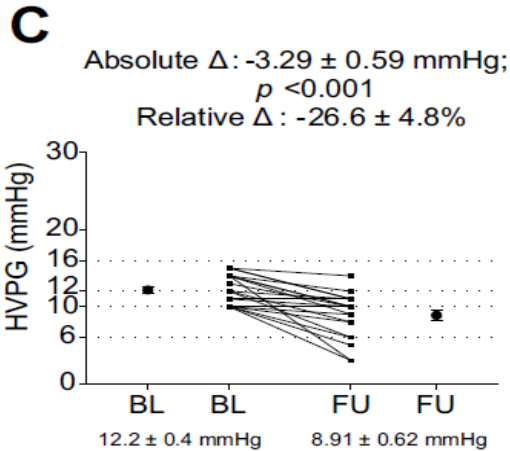
# Fibrosis and LSM after SVR-DAA



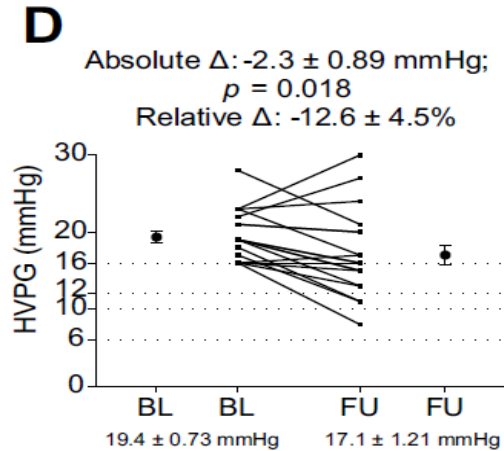
-60 cirrhotic HCV patients  
-SVR with DAA  
-HVPG pre and post



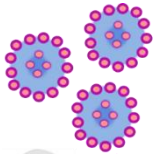
Basal HVPG  
<10 mmHg



Basal HVPG  
10-15 mmHg



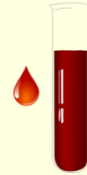
Basal HVPG  
≥16 mmHg



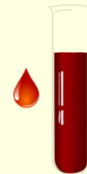
HCV  
oral antiviral  
therapy



### Follow-up non-invasive tests



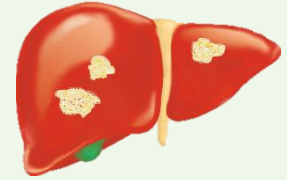
$\geq 20$  kPa  
or  
10-20 kPa + Albumin  $< 4.4$  g/dL



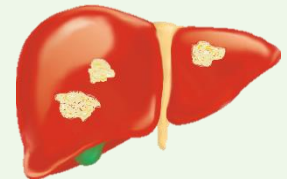
$< 10$  kPa  
or  
10-20 kPa + Albumin  $\geq 4.4$  g/dL



### HCC incidence rates

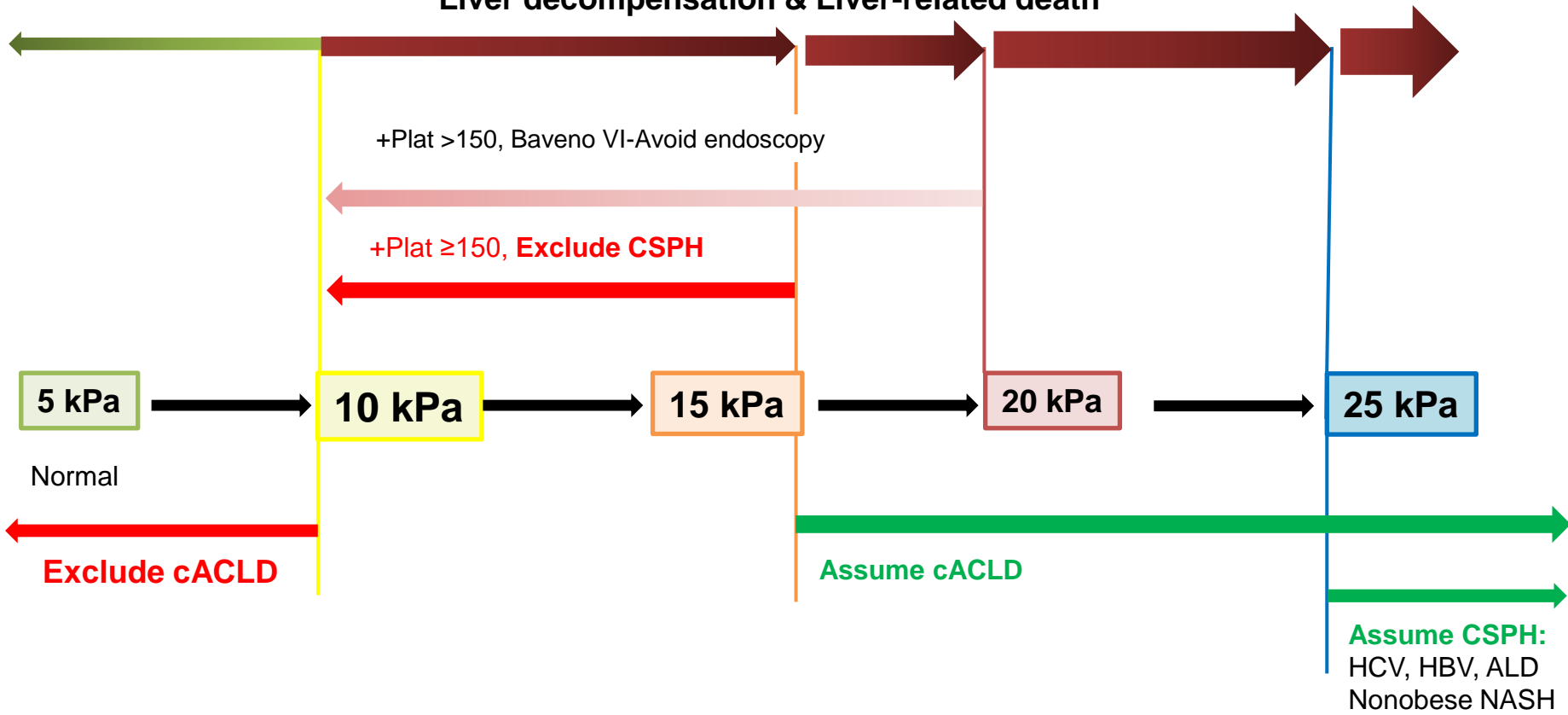


$\geq 1.9/100$  patient-years



$< 1/100$  patient-years

## Liver decompensation & Liver-related death



Non-invasive prediction in cACLD by TE-summary: THE RULE OF FIVE





## Baveno VII

- In the absence of co-factors, patients with HCV-induced cACLD who achieve SVR and show consistent post-treatment improvements with **LSM values of <12kPa and PLT >150x10<sup>9</sup>/L can be discharged from portal hypertension surveillance (LSM and endoscopy)**, as they do not have CSPH and are at negligible risk of hepatic decompensation. **In these patients, hepatocellular carcinoma surveillance should continue until further data is available.** (B1) (New)
- cACLD patients **on NSBB therapy with no evident CSPH (LSM <25kPa)** after removal/suppression of the primary aetiological factor, should be considered for repeat endoscopy, preferably after 1-2 years. In the absence of varices, NSBB therapy can be discontinued. (C2) (New)

## Baveno VII

- **Carvedilol is the preferred NSBB in compensated cirrhosis**, since it is more effective in reducing HVPG (A1), has a tendency towards greater benefit to prevent decompensation and towards better tolerance than traditional NSBBs and has shown an improvement in survival (B1) compared to no active therapy in compensated patients with CSPH. (Changed)
- There is no evidence that endoscopic therapies such as EBL or glue might prevent ascites or hepatic encephalopathy. (D1) (New)
- In patients with ascites and low-risk varices (small [ $<5\text{mm}$ ], no red signs, not Child C), NSBB or carvedilol may be used to prevent first variceal hemorrhage. (B2)
- In patients with ascites and high-risk varices (large varices [ $\geq 5\text{ mm}$ ]), or red spot signs, or Child C), prevention of first variceal hemorrhage is indicated, with NSBB or *carvedilol*? being preferred over endoscopic variceal ligation (EVL). (B1)(Changed)
- In compensated patients with high-risk varices who have contraindications or intolerance to NSBB, endoscopic band ligation is recommended to prevent first variceal bleeding. (A1) (Changed)
- The decision to treat with NSBBs should be taken when clinically indicated, independent of the possibility of measuring HVPG (B2) (Unchanged)

# Dosificación de beta-bloqueantes en cirrosis

## Recomendaciones

### Pacientes sin ascitis

- Frecuencia cardiaca 50-55 lpm o dosis máxima tolerada
- BB (propranolol) titular dosis de 20 → **160 mg/d** (en 2 dosis)
- Carvedilol titular dosis de 6.25 → 12.5 mg/d

### Pacientes con ascitis

- Frecuencia cardiaca 50-55 lpm o dosis máxima tolerada
- BB (propranolol) titular dosis de 20 → **80 mg/d** (en 2 dosis)
- Carvedilol: **evitar!!**

### Pacientes con ascitis refractaria

- **Evitar !!**

### Suspender/reducir la dosis BB en pacientes

- Presión arterial sistólica <90 mmHg
- Daño renal agudo (AKI)

### Reiniciar BB

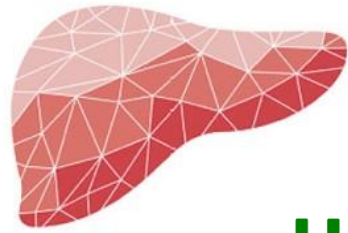
- tras la normalización de los parámetros anteriores
- especialmente en la prevención del resangrado
- re-titular comenzando por dosis bajas

*G Garcia-Tsao et al. AASLD guidelines. Hepatology 2017  
Consenso de Baveno VI. JHEP 2016  
Personal*

### Baveno VII

In patients with ascites, NSBBs or carvedilol should be dose-reduced or discontinued in case of persistently low blood pressure (**systolic blood pressure <90 mmHg** or mean arterial pressure <65 mmHg) **and/or HRS-AKI** (B1). Once blood pressure returns to baseline and/or HRS-AKI resolves, NSBB can be re-initiated or re-titrated (B1).

If a patient remains intolerant to NSBB, EVL is then recommended to prevent variceal hemorrhage (Changed)



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