Guest Editorial

Management of Cirrhotic: Double Edged Sword

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Introduction:

Cirrhosis of liver has been the centre of attention for all the gastroenterologists for decades in terms of different manifestations and complications and at the same time very challenging to manage.[1] There has been some success but not complete eradication of the disease as the risk factors including chronic hepatitis B, C, autoimmune hepatitis , Wilson disease, and most importantly alcohol especially in the western countries remain a daunting task to treat.[2] Those who are compliant to treatment are relatively easy to address. Without treatment the complications are devastating leading to the death of the patient.

The outcomes of the cirrhosis can range from portal hypertension to annihilating hepatocellular carcinoma.[3] The listing of such patients with appropriate indications for liver transplantation is extremely difficult in our country where centres are already overcrowded with referral from all parts.[4] Without effective treatment liver can progress to hepatocellular carcinoma (HCC), accounting for 3.5% of worldwide deaths.[5] Though there have been strenuous efforts to prevent all these , it's a futile exercise keeping in view the suboptimum health facilities and poor management of the patients. The high rejection rate of liver transplant and post operative infection have added to the misery of the patients who are at brink of dying from the disease itself.[6]

Oesophageal varices start developing as a result of long term portal hypertension. There has been reasonably good success at prophylaxis of bleeding with beta blockers and regular surveillance by endoscopy.[5] The most dangerous moment is when the patient presents suddenly at midnight with life threatening acute gastrointestinal bleeding with multiple episodes of hematemesis and malena. Endoscopic variceal bands ligation though one of the definitive treatment needs expertise and functional endoscopic suite with skilled endoscopist[7]. But then it's a team work and sometime building the patient by giving him octreotide or terlipressin for the time being and writing an urgent call to gastroenterology to alert the registrar on the bleeding rota is sensible thing to do as bridging measure. Terlipressin and octreotide are both excellent drugs in variceal bleeding but they have their own side effects including electrolyte imbalance leading to hypoonatremia causing fits.[7]

Hepatic encepathopathy does ensue in cirrhotic quite frequently in patients who are elderly and have coexisting risk factors like gastroenteritis, diabetes, electrolyte imbalance and upper gastrointestinal bleeding. The inpatient mortality is quite high due to this and for that many scoring systems are utilised to predicting the outcome of hepatic encephalopathy patients admitted to the intensive care unit (ICU). The most used scores are Child-Turcotte-Pugh (CTP), Model for End-stage Liver Disease (MELD). The higher the scores, the more difficult it gets.

Non Alcoholic Fatty Liver Disease is another culprit

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that is taken for granted until it leads to burn out and frank cirrhosis .This in other words is a silent disease leading to incredibly nasty consequences .There is a need for screening such patients regularly with scans so as to properly grade them and preventing complications in the long run.[8]

So the management of cirrhosis is indeed a double edged sword as you a stable patient in outpatient department and suddenly decompensating in few weeks time. The room for complacency is minimum as this is a hazardous disease with no discrimination between rich and poor. Liver transplantation is the definitive cure for it after the options such as medications and TIPS (transjugular intrahepatic portosystemic shunt) get exhausted but that too need an ideal setup with excellent post operative care and multidisciplinary team input.[9]

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