PORTAL HYPERTENSION

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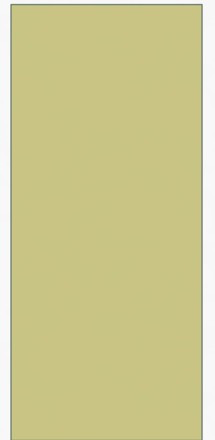

CAUSES

- Cirrhosis
- Non-cirrhosis

Classification of noncirrhotic portal hypertension

Prehepatic
Portal vein thrombosis
Splenic vein thombosis
Splanchnic arteriovenous fistula
Splenomegaly (lymphoma, Gaucher's disease)
Intrahepatic
Presinusoidal
Schistosomiasis
Idiopathic portal hypertension/Noncirrhotic portal fibrosis/Hepatoportal sclerosis
Primary biliary cirrhosis
Sarcoidosis
Congenital hepatic fibrosis
Sclerosing cholangitis
Hepatic arteriopetal fistula
Sinusoidal
Arsenic poisoning
Vinyl chloride toxicity
Vitamin A toxicity
Nodular regenerative hyperplasia
Postsinusoidal
Sinusoidal obstruction syndrome (Veno-occlusive disease)
Budd-Chiari syndrome
Posthepatic
IVC obstruction
Cardiac disease (constrictive pericarditis, restrictive cardiomyopathy)

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SYMPTOMS

- Asymptomatic
- Complications
  - Gastroesophageal varices
  - Ascites
  - Splenomegaly
  - Underlying disease

BLEEDING PREVENTION

- Approximately one-third of all patients with varices will develop variceal hemorrhage
- A major cause of morbidity and mortality in patients with cirrhosis
- AASLD RECOMMENDATIONS — Recommendations for prevention of variceal bleeding have been issued by the American Association for the Study of Liver Diseases

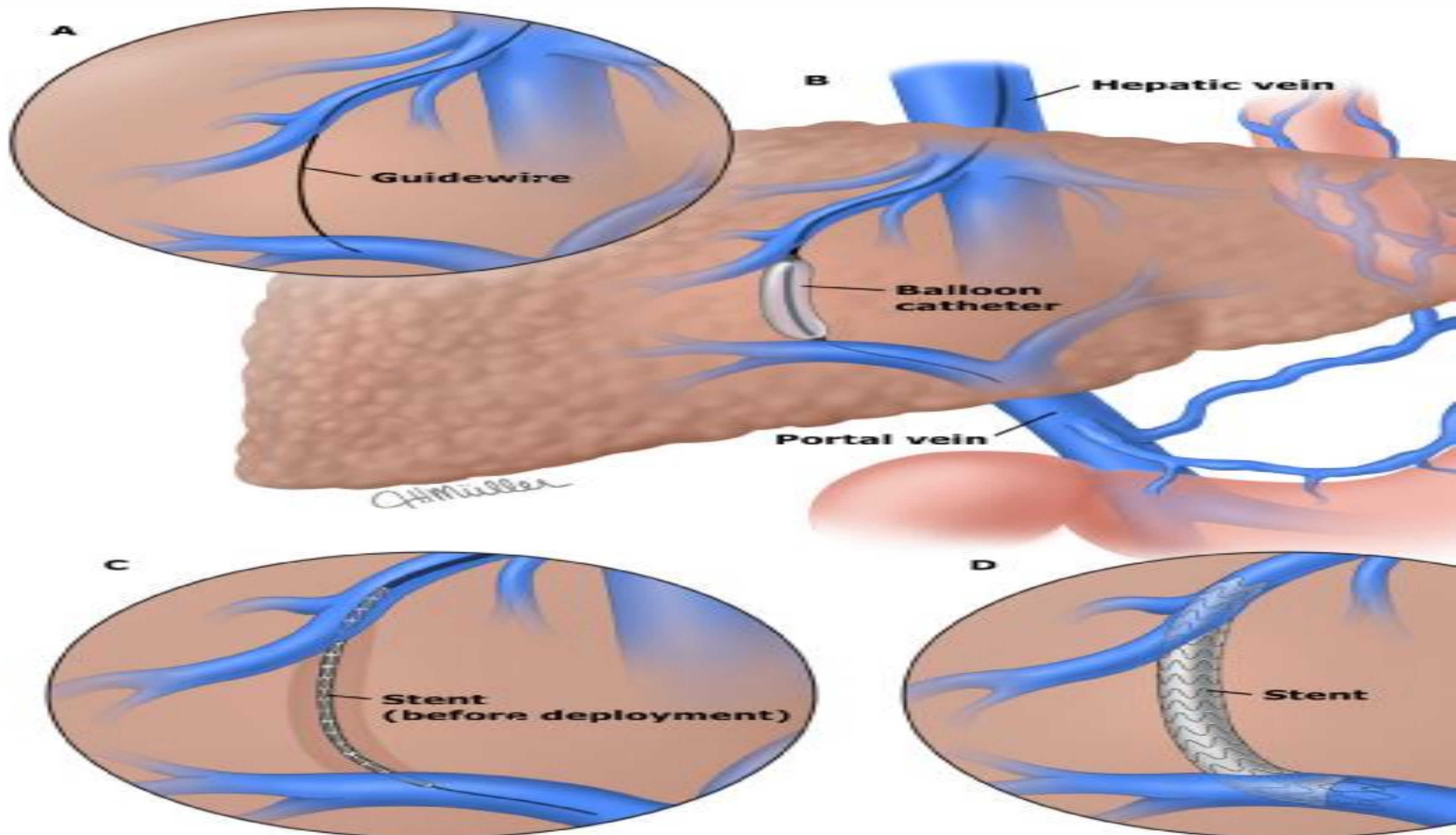
TREATMENT OF BLEEDING

- Initial therapy: hemodynamic resuscitation, prevention and treatment of complications
- Prophylactic antibiotics, preferably before endoscopy (although effectiveness has also been demonstrated when given after).
- Suggest intravenous ceftriaxone (1 g IV) or Cipro (400 mg IV BID)
- UGD should be performed for diagnosis and possible treatment
- Octreotide (50 mcg bolus followed by 50 mcg/hour by intravenous infusion) where terlipressin is unavailable

CONTINUE

- Salvage treatment
  - TIPS (transjugular intrahepatic portosystemic shunt)
  - Surgery in well preserved liver function who fails emergent endoscopic treatment and has no complications from the bleeding or endoscopy.
  - The choice of surgery usually depends upon the availability, training, and expertise of the surgeon. Although a selective shunt has some physiologic advantages, it may significantly exacerbate marked ascites.

Transjugular intrahepatic portosystemic shunt



A transjugular intrahepatic portosystemic shunt (TIPS) is cre
passing a needle catheter via the transjugular route into the
and wedging it there. The needle is then extruded and advar
the liver parenchyma to the intrahepatic portion of the portal
stent is placed between the portal and hepatic veins. A TIPS
side-to-side surgical portacaval shunt, but does not require
anesthesia or major surgery for placement. (A) Passage of a
between the hepatic vein and the portal vein. (B) Inflation of
catheter within the liver to dilate the tract between the hepat
portal vein. (C) Deployment of the stent. (D) Stent in its fina

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LIVER RESECTION

- Indications:
  - Benign:
    - Tumor
      - Adenoma
  - Malignant:
    - Primary:
      - HCC
      - CC
    - Mets:
      - CRCLM

LIVER RESECTION

- Outcomes
  - Benign
  - Malignant
- What's resectable
  - How much liver
  - Can we do anything else

HCC VS. CRCLM

- Background liver
- Associated morbidities
- Transplant options

LIVER RESECTION

- Complications
  - Liver Failure
  - Bleeding
  - Bile leaks
  - Infection (wound, deep abscess)
  - General complications

LIVER RESECTION

- Types of resections