

The management of portal hypertension and esophageal varices

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Abstract

The main reason behind malignant hypertension and of the formation of esophago-gastric varices is cirrhosis of the liver. The prevalence of cirrhosis has been estimated at around 0.15% within the us, with data that are substantially similar in Europe, with even higher numbers in most African and Asian countries (where chronic hepatitis B or C are common). Another explanation for malignant hypertension is schistosomiasis, affecting 200 million people worldwide. Right heart condition, pericarditis, Budd-Chiari syndrome, inferior vena thrombosis, extra-hepatic tumors (biliary tract, pancreas, stomach, retroperitoneum) cause malignant hypertension. From the purpose of view of the Endoscopist Gastroenterologist, the most complication of this syndrome is digestive hemorrhage, which is additionally the most reason behind death of the cirrhotic patient and of the patient with malignant hypertension. during this presentation, the methods to diagnose this disease are reported with respect to the calculation of the danger of bleeding and therefore the therapeutic techniques of prophylaxis and therapy of the acute event. If you have got cirrhosis, your doctor should screen you for esophageal varices when you're diagnosed. How often you'll undergo screening tests depends on your condition. Main tests accustomed diagnose esophageal varices are Endoscopic exam. A procedure called upper gastrointestinal endoscopy is that the preferred method of screening for esophageal varices. Your doctor inserts a skinny, flexible, lighted tube (endoscope) through your mouth and into your esophagus, stomach and also the beginning of your intestine (duodenum).

The doctor will hunt for dilated veins, measure them, if found, and check for red streaks and red spots, which usually indicate a big risk of bleeding. Treatment are often performed during the exam. Imaging tests. Both abdominal CT scans and Doppler ultrasounds of the splenic and portal veins can suggest the presence of esophageal varices. An ultrasound test called transient elastography that measures scarring within the liver can help your doctor determine if you've got malignant hypertension, which can cause

esophageal varices. Capsule endoscopy. during this test, you swallow a vitamin-sized capsule containing a small camera, which takes pictures of the esophagus because it goes through your channel. This may be an option for folks that are unable or unwilling to possess an endoscopic exam. This technology is dearer than regular endoscopy and not as available. Capsule endoscopy can only help find esophageal varices and doesn't treat them. malignant hypertension could be a frequent consequence of disease, especially alcoholic cirrhosis. Unabated elevations in portal pressure may presage an esophageal variceal hemorrhage. Propranolol or isosorbide therapy is effective within the prophylaxis of variceal bleeding. In patients with acute variceal hemorrhage, endoscopic sclerotherapy or ligation is that the best initial intervention. Stapled esophageal transection is usually effective when endoscopic management fails. Surgical shunts have a lower associated death rate once they are performed electively and involve partial shunting of hepatic blood flow. Transjugular intrahepatic portosystemic shunts are indicated as a salvage procedure or as a bridge to liver transplantation. Ultimately, liver transplantation offers the simplest survival rate. Cirrhosis of liver could be a major problem within the western world. malignant hypertension may be a complication of cirrhosis and may cause a myriad of pathology of which include the event of porto-systemic collaterals. Gastrointestinal varices are dilated submucosal veins, which frequently develop at sites near the formation of gastroesophageal collateral circulation.

The incidence of varices is on the increase thanks to alcohol and obesity. the foremost significant complication of malignant hypertension is life-threatening bleeding from gastrointestinal varices, which is related to substantial morbidity and mortality. additionally, this could cause a big burden on the health care facility. Gastrointestinal varices can happen in esophagus, stomach or ectopic varices. There has been considerable progress made within the understanding of the explanation, pathophysiology and etiology of malignant hypertension. Despite the event of endoscopic and medical treatments, early mortality because of variceal bleeding remains high thanks to significant illness of the patient. Recurrent variceal bleed is common

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and in some cases, there's refractory variceal bleed. this text aims to supply a comprehensive review of the management of gastrointestinal varices with a stress on endoscopic interventions, strategies to handle refractory variceal bleed and newer endoscopic treatment modalities. Early treatment and improved endoscopic techniques can help in improving morbidity and mortality. malignant hypertension refers to a pathological elevation of portal blood pressure resulting from obstructions in portal blood flow, which can be either prehepatic (e.g., vein thrombosis), hepatic (e.g., liver cirrhosis), or posthepatic (e.g., right-sided heart failure). the following backflow of blood may cause portosystemic anastomoses, splenomegaly, and/or ascites. While malignant hypertension is also diagnosed purely supported the presence of clinical signs

and potential risk factors, medical imaging and laboratory tests are wont to support the diagnosis in suspected cases.

Management requires treating the underlying condition and reducing portal pressure with nonselective beta-blockers and portosystemic shunts A potentially life-threatening complication is acute hemorrhage of the esophageal varices caused by increased blood flow via portosystemic anastomoses. Patients present with sudden hematemesis and melena, still as shock in some cases. additionally to stabilizing the patient, acute management of variceal bleeding includes reducing splanchnic blood flow with octreotide and endoscopic variceal band ligation. Prevention of (recurring) bleeding involves nonselective beta-blockers, endoscopic variceal ligation, or placement of transjugular intrahepatic portosystemic shunts (TIPS).