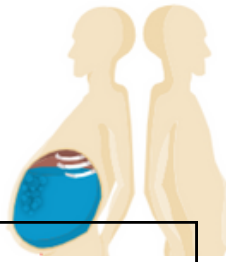
Specific Management

Ascites in a patient with cirrhosis

Specific management



Mild

Moderate

Tense

Large-volume (≥5L) paracentesis + start with diuretics if no contraindications

- Give 25% albumin 100cc for every 3L removed

*if concern about SBP or patient has renal dysfunction, do not remove >5L over 24 hours

*Remove paracentesis catheter the same day

Dosing for Spironolactone monotherapy

- **Spironolactone** 50-100mg PO QAM starting dose

- **Do not use this medication alone in patients with hyperkalemia**
- **May cause painful gynecomastia**

See more info on Substituting Spironolactone with Amiloride

Substituting Spironolactone with Amiloride

More info on Spironolactone/Furosemide dosing ratio

In patients on diuretics, monitor the following:

- Q weekly weights (aim for up to 0.5kg of fluid loss/day; those with pedal edema may tolerate up to 1 kg/day
- Q 1-2 weekly creatinine and electrolytes as doses are being increased. Extend to Q2-3 monthly once tolerating a stable dose

YES

NO

How to titrate up diuretics

- Increase every 3-7 days as tolerated
- Can double doses if weight loss <2kg a week and creatinine, electrolytes ok
- Adjust more cautiously and once ascites and edema are cleared, begin to taper diuretics to their lowest effective dosage

More info on Spironolactone/Furosemide dosing ratio

- Maximum doses Furosemide 160mg, Spironolactone 400mg
- If there is an inadequate response to diuretics, you can use the urinary sodium to check for dietary non-compliance or resistance to diuretics

See more info on using the urine sodium

Does the patient meet diagnostic criteria for refractory ascites?

- Diuretic-induced complications (renal dysfunction, hyponatremia)

OR

- Non-response to diuretics

If paracentesis ≥3 times in a year (= Recurrent ascites)

- Discuss alternative therapies with a liver specialist if this hasn't been done (i.e., TIPS, transplantation, indwelling pleural catheter)

Transjugular Intrahepatic Portosystemic Shunt (TIPS)

Ascites - Indwelling Pleural Catheters (IPCs)