Discussion: The mortality at six weeks and early rebleeding, as well as mortality predictors, match what is reported in the international literature.

Conclusions: Poor hepatic function reserve, which is related to higher comparisons of Child-Pugh and MELD scores, are independent predictors of mortality in variceal bleeding due to the high portal venous pressure gradients managed by these patients. Similarly, the presence of other decompensations, such as acute kidney injury, hepatic encephalopathy, and ACLF, also increase the risk of death when they occur in conjunction with variceal bleeding.

Funding: The resources used in this study were from the hospital without any additional financing

Declaration of interest: The authors declare no potential conflicts of interest.

TABLE 1. Variables

Age (mean)	58 years	Types of varicose veins	Esophageal 42(60%)
Cirrhosis etiology	Viral 16(22.9%)		Gastrofundic 11(15.7%)
	Alcohol 14 (20%)		Both 15(21.4%)
	MAFLD 9(12.9%)	Endoscopy-bleeding time	Less than 12 hours 27(38.6%)
	Autoinmune 7(10%)		less than 24 hours 34(48.5%)
	Not determined 22(31.4%)		More than 24 hours 8(11.4%)
	No cirrhosis 2(2.8%)	Triggers/descompensations	Portal thrombosis 13(18.5%)
Bleeding episode number	First episode 25(35.7%)		AKI 18(25.7%)
	Second episode 28(40%)		HE 15 (21.4%)
	Third o more 17(24.2%)		ACLF 15(21.4%)
Child-Pugh score	Class A 14(20%)		SBP 0(0)
	Class B 37(52.9%)		Other infections 12(17.1%)
	Class C 17(24.3%)	ABC score (mean)	7 pts
MELD (mean)	15 pts	Glasgow-Blatchford (mean)	11 pts
Active bleeding (jet)	7(10%)	Rockall score (complete) (mean)	6 pts
Transfusión (mean)	1.5 globular concentrates	AIMS 65 (mean)	1 point
Hospital stay (mean)	5.2 days		

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An unusual complication after variceal band ligation: complete esophageal obstruction, a case report and review of the literature

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Introduction and objectives: Endoscopic ligation is the standard therapy for secondary prophylaxis of variceal bleeding, being a simple procedure, although not without complications. A case of a rare complication is presented.

Clinical case summary: 73-year-old woman with cirrhosis and a history of variceal bleeding in secondary prophylaxis. Endoscopy was performed, presenting large esophageal varices with high-risk bleeding stigmas data with ligation of 2 varices. Twenty-four hours later, he started with chest pain and progressive dysphagia to liquids and solids. Tomography showed esophageal dilatation with air-fluid level and distal narrowing. She was admitted for hospital surveillance with no response to symptomatic management and no tolerance to oral administration; an endoscopy was performed 72 hours later, observing complete obstruction of the esophagus lumen due to the tissue surrounding varix with edema and necrosis that prevented the passage of the endoscope. Conservative management was decided, with strict fasting and central parenteral nutrition for three days, with complete resolution of symptoms and tolerance to oral administration on day 5. At 12 weeks later, she reported dysphagia; the control endoscopy showed concentric stenosis in the previous ligation site, requiring dilation with a pneumatic balloon to 13 mm. Figure 1.

Discussion: Among the complications after endoscopic band ligation of esophageal varices, the presentation of complete obstruction is the least frequent, finding only 14 cases reported in the literature. Conservative management and monitoring for the development of posterior stenosis are recommended.

Conclusions: Physicians should be aware of all the probable subsequent complications derived from this procedure.

Funding: The resources used in this study were from the hospital without any additional financing

Declaration of interest: The authors declare no potential conflicts of interest.

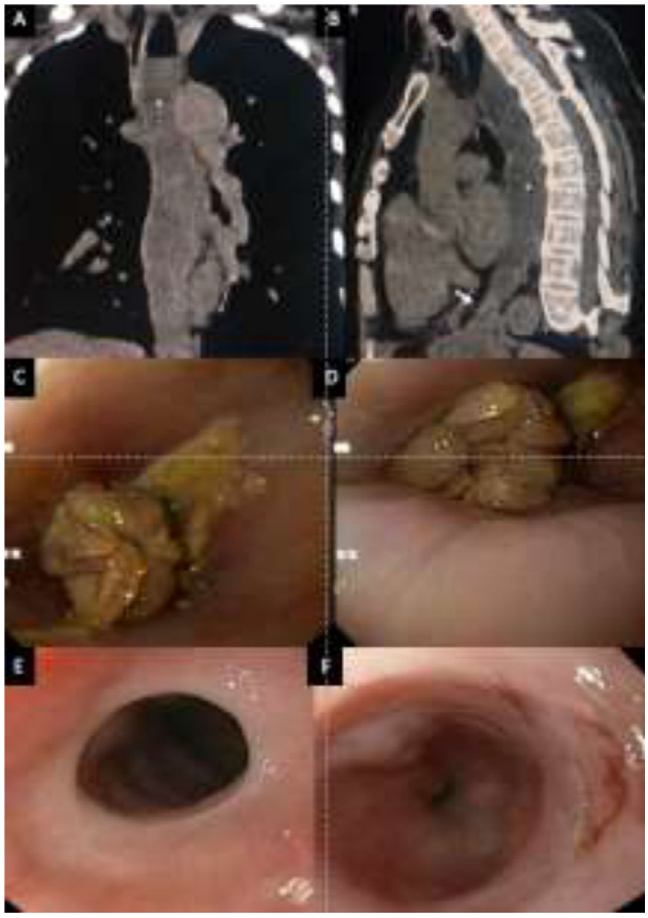

Figure 1. a) Chest CT (coronal) with dilation of the esophagus and an air-fluid level b) Sagittal chest CT, with stenosis in the distal third, c and d) post-ligation endoscopy with a varicose band that obstructs the esophageal lumen, edema and necrosis e) follow-up endoscopy with stenosis due to fibrosis f) post-dilation

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Comparison of the meld-la model as a predictor of early mortality in Mexican patients with chronic decompensated liver disease

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Introduction and Objectives: Here are several scales used to predict early and long-term mortality in patients with chronic decompensated liver disease; the sensitivity is different in each one. A study published in the AASLD 2002 evaluated the MELD-LACTATE scale with good results. This scale has not yet been evaluated in the Mexican population. Evaluate the sensitivity and specificity of MELD-LA to predict early mortality in patients with decompensated cirrhosis in Mexican patients

Materials and Methods: Observational, retrospective, comparative, longitudinal study evaluating early mortality (after 15 days) of Mexican patients with decompensating cirrhosis who were given the MELD-LA scale upon admission to assess its predictive capacity. Patients with decompensated cirrhosis of any etiology were included, mortality at 15 days was evaluated, descriptive statistics were performed, and inferential with ROC curves.

Results: Two hundred thirty-eight patients were included, of which 100 were analyzed; 33 men and 66 women, minimum age 27 and maximum 84 years, mean 51 years, SD 11.7. Alcohol was the main cause of cirrhosis, and the most common cause of decompensation was sepsis. The MELD-LA score performed better in predicting mortality at 15 days; sensitivity and specificity were 0.84 and 0.59; providing the highest AUC was 0.72. The results are shown in figure 1.

Conclusions: The MELD-LA score was shown to be an early and objective predictor of hospital mortality in Mexican cirrhotic patients.

Funding: The resources used in this study were from the hospital without any additional financing

Declaration of interest: The authors declare no potential conflicts of interest.

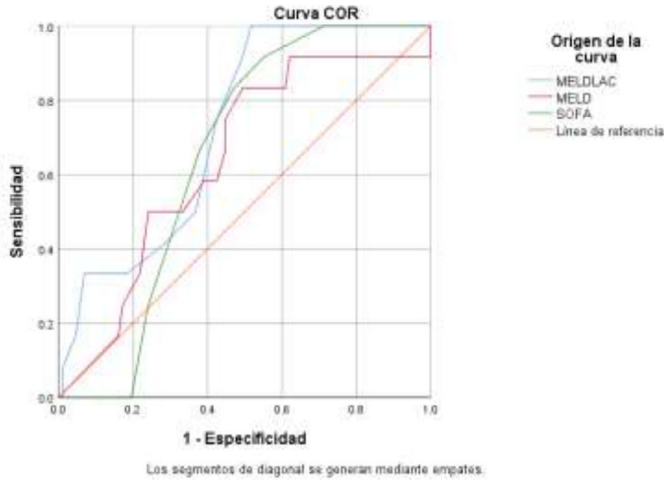

Figure 1.
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Norepinephrine in infusion as an alternative to large volume post-paracentesis albumin in patients with cirrhosis

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Introduction and Objective: Circulatory dysfunction syndrome (DCIP) occurs in patients who undergo large-volume paracentesis. Albumin should usually be administered to prevent it. However, in many cases, this resource is not available. Singh V, Kumar B, *et al.* published a study evaluating norepinephrine in preventing DCIP with promising results. This study aimed to assess whether norepinephrine is a helpful resource in preventing DCIP when albumin is unavailable.

Materials and Methods: A prospective, descriptive, and analytical study includes patients with cirrhosis and grade III ascites. Given norepinephrine as an alternative to albumin to prevent DCPI, patients with kidney injury, shunts, and gastrointestinal bleeding were excluded. Descriptive statistics were performed, comparing creatine, Ngal, nystatin C, and sodium at days 0, 3, 6, and 28 days, evaluating whether or not DCPI developed. The trial was approved by the research ethics committee, and informed consent was obtained.

Results: Twelve patients were included, one of whom was ruled out due to precordial pain without electrocardiographic changes; 11 patients were analyzed; 9 men (81.8%); age 52.2 ± 4.5; and 2 (18.2%) P and 9 (81.8%) Child C; 8 (72.7%) due to alcohol, 2 (18.2%) MAFLD, 1 (9.1%) HCV; the drained liters of ascites were 12.5 L with a range of 9 to 18; Renal function measured by creatinine, Cystatin C and NGAL at 0, 3, 6 and 28 days did not show renal dysfunction. The results are shown in Figure 1.

Conclusions: Norepinephrine promises to be an alternative for the preventive management of DCPI.

Funding: The resources used in this study were from the hospital without any additional financing

Declaration of interest: The authors declare no potential conflicts of interest.

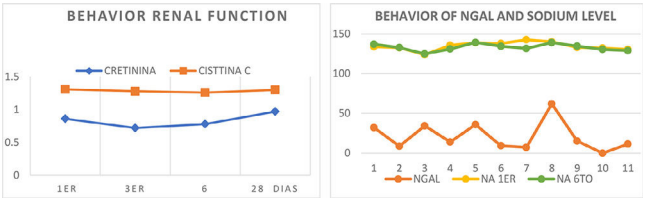

Figure 1
https://doi.org/10.1016/j.aohep.2022.100797

Management of internal hemorrhoidal bleeding refractory to endoscopic treatment in a patient with liver cirrhosis

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Introduction and Objectives: Hemorrhoidal bleeding associated with portal hypertension is a rare complication. Endoscopic management is the initial treatment recommended. There are no established guidelines in refractory bleeding; we present a patient with hemorrhoidal bleeding refractory to endoscopic treatment.

Clinical case: A 72-year-old woman with decompensated liver cirrhosis and hemorrhoidal disease presented hemorrhoidal bleeding treated with endoscopic band ligation; five days later, rectal bleeding returned. Colonoscopy showed post-ligation ulcers and active bleeding; endoscopic bleeding control with band ligation and sclerotherapy was not achieved (Image 1A-1B). Venography of hemorrhoidal veins and embolization with coils and Histoacryl was performed, achieving bleeding control (Image 1B-C), and hepatic-portal vein gradient was measured (33 mmHg).

Discussion: Symptomatic hemorrhoidal disease in liver cirrhosis has a prevalence of 5%, and it is associated with greater vascular collaterality, coagulopathy and high surgical risk. The treatment options go from endoscopic band ligation, sclerotherapy and arterial or vein embolization, with rebleeding rates between 10-13% in different case