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.

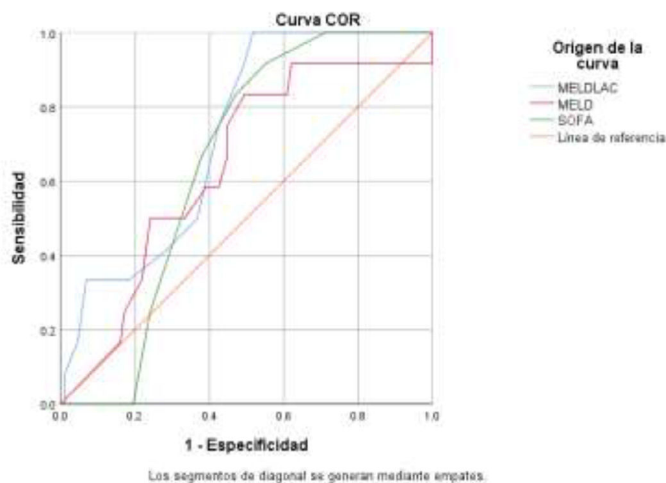

Figure 1.

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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.

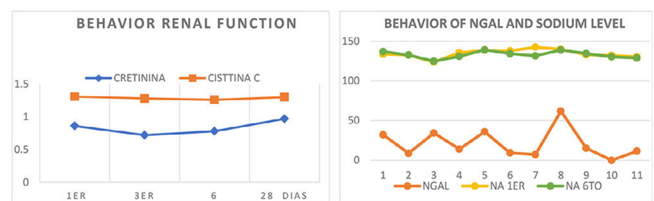

Figure 1

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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