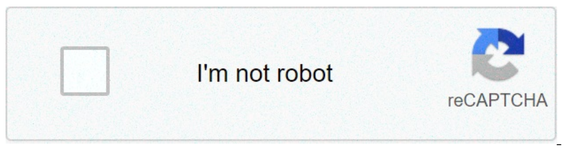

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Hemorragia varices esofagicas pdf

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Primo Misapintes, and with a schematic evaluation target the different processes and treatments applicable to the different cases of Varicose Esophagic varices, we face the treatment and prevention of it general. To deepen and emphasize in each of them more comprehensively. One of the first mechanisms for the treatment of varicose Varicose Esophagic must be aimed at preventing hemorrhages so, since it is the one that more complications for the patient, being able to become a cause of death. On the contrary, we must say that there are no warranties of treatment that a patient does not have a bleeding from Varic Esophagic varices, but a certain decrease this possibility. In this regard, bleeding can be avoided with the treatment of the underlying causes of liver disease and with a preventive treatment of vatures with drugs such as not selective beta-blockers as Ã ¢ â,¬ å "propanolá â,¬ and Ã ¢ â, ¬ Å "NadoloLÃ ¢ â,¬, indicated for all patients with varicose veins that tolerate them. They are drugs that have been designed as antihypertensive surgery (medicines for arterial hypertension), but they have the property to lower the pressure of the vein leads to some patients. The different studies and treatments have constantly demonstrated that these beta-blockers reduce the possibility of bleeding in both patients who never have bleeding and those who have already had episodes of bleeding before. However, these drugs are not useful for preventing the development of Esophagic varicose veins in patients. With the same purpose to prevent bleeding and for those patients who have contraindications or not tolerate propanolol, both in terms of ever a previous episode of bleeding their Esophagic vatures. A prevention can be developed by an endoscopic treatment treatment, which proceeds to directly inject the varicose veins with a coagulant agent, to avoid bleeding, or make an elastic around the bleeding vein itself, such as endoscopic binding to alleviate any bleeding. This treatment should also be used to avoid new bleeding in those patients who have already undergone hemorrhage processes first in their Esophagic fins, as well as for the correction of cases of bleeding or acute bleeding. Once the prevention of vein bleeding is not possible and we are faced with a clinical picture of Esophagic pallets with bleeding or bleeding, we must place the immediate treatment of the patient. For which a treatment was proposed whose main purpose is to stop bleeding as soon as possible and treat the persistent palettes through therapies and methods of methods. A hemorrhage that must be checked quickly to avoid a hypovological Å "Ship Ã ¢ â,¬, and in the absence of that death. Furthermore, if a widespread bleeding is presented, the patient can be placed in a respirator to protect the stretch and avoid respiratory bronchease of blood. With all of them and when it comes to increasing any treatment, this should pursue and consider three primordial and very important aspects: first of all the treatment and addressed of active bleeding, resulting in flight control. By further preventing the aspect of haemorrhage complications (bacterial infections, hepatic failure and renal failure) and reach the emostasis of Variz Bleeding. The prevention of the hemorrhagic anniversary, of the reappearance of the same shortly after the period of convalescence. And a final prophylastic treatment of preventive medicine. In the vast majority of cases, not to say in its entirety, in which we are faced with an active hemorrhage, and The gravity of Esophagic hemorrhage, its treatment will be possible only in intensive care unit. It must be taken into account that patients with portal hypertension often develop a significant alteration of the mental state from hepatic encephalopathy, so the protection of variety should be considered by endotracheal intubation. Moreover, and often the transfusion of frozen platelets and fresh plasma is often necessary for the correction of a coagulopathy, together with centrifuged erythrocytes to counteract the volume deficit. It is important to keep the patient prepared with an intravenous cave of gauge thickness that allows rapid transfusion in the event that it is necessary if it suffers from a stretch Ã ¢ â,¬ Å "Ã ¢ â,¬ hypovolish. Similarly, avoiding the prolonged hypotension of the patient is the most appropriate method to avoid complications such as infections, renal failure and deterioration of hepatic function, closely associated with the risk of containment and death. Furthermore, and even if it has been shown that the administration of plasma expanders can produce an increase in portal pressure and can increase the risk of recurrence bleeding, the fact must be taken into account that the use of vasoactive drugs (vasopressin analogues or somatostatin) prevents the increase in volume-expansion induced portal pressure, which allows a repositioning policy of the volume of less conservative. Furthermore, concentrated hematins must be transferred to maintaining the hemoglobin level about 7-8 gr / dl 2, except in patients with significant hemorrhages or coronary heart disease. All other important aspect in the patient's initial treatment is antibiotic prophylaxis; Infection is an important prognostic factor in acute digestive hemorrhage from varicose vehicles. About 20% of patients with cirrhosis and digestive hemorrhage are infected at the time of diagnosis and 50% will develop some infection during the hospitalization period. Most frequent infections are bacterial spontaneous peritonitis (50%), urinary tract infections (25%) and pneumonia. The use of acute antibiotics bleeding varicose veins has shown that it reduces both the risk of withholding and mortality. Therefore, antibiotic treatment must be established in all patients from the time of hospitalization. The most used drugs have been the chinolones given their easy administration and low cost. A recent study has shown that in high-risk patients (hypovological impacts, ascites, jaundice or malnutrition) Cetriaxone IV is superior to Norfloxacin. Finally, we must emphasize that currently within the set of initial treatments raised up to date, the role of hemostasis (coagulopathy and trombocytopenia disorders) is unknown in the evolution of bleeding and the effect of replacement therapy (fresh plasma, platelets ,. ..). Although once all these processes have been performed and when patients have good urinary volume, stable arterial pressure, improvement of tachycardia, adequate peripheral peripheral peripheral and hematker in spectrum 25% to 30%, the administration of liquid can be reduced At maintenance levels. However, none of these actions is aimed at correction of hemorrhage varics, but for the control, stabilization and prevention of patient complications. To be able to group the various treatments applicable to the correction of bleeding in two groups in bleeding intensity: in this way, and for the acute bleeding treatment of vein varices, different methods, such as; Endoscopic therapies previously mentioned in the mechanisms of Be through injection of coagulant agents or exophagic vatures tying from elastic bands. The use of drugs such as Ã ¢ â,¬ Ã â â,¬ â,¬ or Ã ¢ â,¬ à "vasoprisinaÃ ¢ â,¬ restricted blood vessels from vasoconstriction, favoring reducing the flow of blood portal and reduction of hemorrhage. O The Tamponing of Esophagic veins from the pressure exercised on this is introducing a probe from the stomach nose and inflating with air, in so-called Ã ¢ â,¬ Å "trap with balloon â,¬. Once acute haemorrhage is stopped, the possibility of carrying out a complementary treatment is raised by placing a catheter through a vein along the liver. Finalized procedure is that the blood vessels of the portal to the regular veins in the body is connected, reducing the pressure in the venous portal system. This process is known as a transcyugular trial of intraepathic portrosisthemic derivation or suggestions. For the treatment of serious hemorrhages, all methods raised previously in cases of acute bleeding can be applied; Endoscopic therapies, use of vasoconstrictor drugs, connecting Esophagic veins from Ã ¢ â,¬ Å "Tapment with balloonÃ ¢ â,¬ or probe, as well as the realization of an intraepatic transcyugular portrosisthel derivation or suggestions once bleeding is He stopped. However, due to gravity and risk represented by a serious hemorrhage, when none of the previous therapies were successful, which is very strange, three new treatments as they are; The execution of emergency surgery. Á, â,¬ Å "derivaciÃ³n portocavavaÃ ¢ â,¬, a treatment in which a connection between the brings vein is established, which irrigates 75% of the liver, and the lower quarry cava that drains blood from two thirds of the body. And surgical removal of a portion of the esophagus. Presenting the last two procedures of a high mortality rate. In any case, the initial therapy will be endoscopic and / or pharmacological, with the rest of the processes and interventions had the purpose of rescue therapy in the event that the initial therapy fails. Made that it is usually produced in 10-20% of patients with hemorrhage varics. Regardless of bleeding intensity, and once this has stopped, veins can be treated with different drugs or methods to prevent the reapparty from a new future hemorrhage. These treatments are already mentioned in the initial bleeding prevention; The use of beta-blocking drugs and the use of endoscopic therapies. As well as the creation of a Transcyugular portrosyugular or tips intraepathic derivation procedure. Finally, and before moving to the detailed and individual study of any treatment we have signs as in those patients with bleeding vatures at the bottom of a liver disease, they may need further treatment of their disease, including a Hygingan transplant. Similarly it seems to me interesting to verify how in the last studies on the treatment of varicus hemorrhages Varicos Varicose Esophagic were achieved unique results with the association of beta-blockers (as Ã ¢ â,¬ å "nadololÃ ¢ â,¬) and nitrates Organic (like IsosorbidaÃ ¢ â,¬ Ã â,¬) in secondary prophylaxis of varicose varicose varicose bleeding. Clinical studies carried out more than 18 months, in which the mortality, recurrence of hemorrhagic processes and complications attributed to the treatment of sclerotherapy have been reduced by 50.55%, compared to sclerotherapy, compared to sclerotherapy, considered so far as Therapeal reference in this type of processes. Once the different treatments applicable to varicose are stated and its application in the clinical process that will pass to the study of the state and detailed of each of them, with particular emphasis on the greater and most important: endoscopic endoscopy treatment is the basis of the treatment of digestive bleeding and is a mode for diagnosis And therapy. Once it has been identified that the origin and cause of hemorrhage are varicose esophagic varices, treatment options are endoscopic injectable sclerotherapy and ligature with varicishes elastic bands. Being both processes useful both for the prevention of bleeding and control and correction, especially when it comes to hemorrhage and acute bleeding processes. Endoscopic sclerotherapy (ETE): a variety of techniques were used to carry out endoscopic sclerotherapy with the aim of stopping acute bleeding and recurrence prevention, through varicies' obliteration through repeated injections of coagulant agents. Injections can be directed towards veins (intravaric injection) or towards the esophagic wall adjacent to varicose channels (paravarian injection). Both techniques are effective, but most researchers prefer intravaric injection. Another variable to be taken into consideration are the substances used in these injections, so we can have several different sclerphones such as 5% sodium morrued "Á ¢ â,¬ Å" blow-up tetradecil sodium 1 % to 3%, 5% ethanolanineÃ ¢ â,¬ Å "olornine, polydocanol of 0.5% to 1% and high alcohol concentrations. Similarly, they were used with good results in adhesive injections such as Ã ¢ â,¬ oen-butyl-2-cyanoacrylateÃ ¢ â,¬. However, the optimal sclerosing volume that must be injected during a single session Ã © tÃ © is the subject of controversy and medical discussions. Although, as a general rule, 2 ml of sclerosing injection and the total volumes of treatment are usually used to rise at 10 15 ml. The results of the different treatments seem to reveal the existence of potentially important differences between the use of different sclerosing agents, at least as regards adverse reactions. For example, 1.5% sodium tetradecil Ã ¢ â,¬ å "Sodium sulfate can be associated with greater development of ulceration and local narketing, compared to a" polydocanolÃ ¢ â,¬ or Ã ¢ â, â,¬ ¬ Å "EthanolamineÃ ¢ â,¬. However, the use of tissue and adhesive stickers such as Ã ¢ â,¬ oen-butyl-2-cyanoacrylateÃ ¢ â,¬ pose the inconvenience of its difficulty to obtain, as well as greater technical difficulties in the application and a potential risk , although rare, pulmonary embolism. On the contrary, in its favor, this fabric glue is very effective when bleeding is produced by a Variz gastric, being effective for this type of relatively low therapy mode. Endoscopic sclerotherapy as a treatment was associated with a variety of minor complications, in turn, such as toxic pain, transient dysphagia, fever and small pleuric spills. As well as other possible complications associated with the risk of perforation and local infection. In most patients, the formation of ultrasses Esophagic can observe, even if, as a general rule they are not complicated. However, up to 20% of patients, recurrent bleeding takes place from mucosa ulceration. Restrice Esophagic are seen that lead to dysphagia in about 15% of cases, even if their incidence and gravity vary considerably. In these cases, proton pump inhibitors are the most effective treatment for esophagic ultrasses and are also recommended to prevent both ultrasounds and straight after following a treatment with Varician Lighth endoscopic (LEV): The relatively high incidence of complications after ETE has led to the development of an alternative endoscopic treatment consisting of varicose endscopic ligature. This technique is the treatment for simpler varicies and that a lower number of complications poses, implies the positioning of ring bands or elastic bands in varicose veins, with which the strangulation of the veins, control and its phiagent is caused Bloody accordingly. It is a treatment that is carried out through an illuminated fibrotic tube or endoscope, which is introduced through the mouth towards the esophagus, which allows you to see the interested vatures. A small empty room at the endoscope ends allows you to pull the Variz towards an elongated band that will be used for "owl" varices. For this purpose, a trigger device is used that allows bandwidth to be released around the base of the Variz, which causes subsequent death or necrosis and the formation of scar tissue in the struck that interrupts hemorrhage. Band positioning is repeated every one or two weeks until the varicies disappear or are reduced from the size. Often it is a treatment that requires four to six interventions. We need to note that to facilitate repeated Esophagic intubation, varicose endoscopic binding requires the use of a plastic survey, since thereby endoscope can be removed to recharge it with a new band after performing each ligature keep the plastic road Examine at any time. The use of this technique during a hemorrhagic process is complicated by the limitation of the visual field. The ligital is usually started at the level of the Gastroesophagic Union, with the positioning of additional bands in the proximal direction. We must also take into account that the realization of the treatment requires the previous stabilization of the patient with the blood administration and intravenous liquids to replace the possible loss caused by hemorrhage and bleeding, in case these are verified. A stabilization process that in some cases can be prolonged from 2 to 12 hours. As well as for some patients, a breathing tube can be positioned on the shuttle (endotracheal intubation) to prevent blood intake towards the lungs during the process. Varicosa endoscopic binding produces less local and systemic complications than ETEs, could be controlled by different medical results that narrowing Esophagic or stenosis from esophagus fibrosis, bleeding caused by treatment-induced treatment, pulmonary infections, bacterial peritonitis and complications leading to death have been Less frequently reported than in the execution of endoscopic sclerotherapy treatment (ETE). However, the objective of the analysis grants only statistical signs for the lowest incidence of strict Esophagic. However, in general terms, the varicose Ethoscopic endScopic tying is a good and effective treatment, resulting in reduction of bleeding in just 20 to 36% of patients. While in those cases in which the realization of endoscopic ligatures is not carried out 70% of people suffer from a recurrence of bleeding, which can lead to death in 12 months. However, for patients suffering from Esophagic bleeding, the result is bad. Hemorrhage from Esophagic palette will cease without treatment in 50% of subjects. Unfortunately, many of these patients will return to bleed over a couple of days, reaching 30% of patients fell when they acute bleeding, even if recurrent bleeding can sometimes be controlled with treatments Pharmacological treatment The pharmacological treatment of hemorrhage from Esophagic varices varices is carried out with drugs whose main purpose is to reduce the splent flow, or blood flow to varicose vatures, and the portal pressure, reducing from those of bleeding risk and Voltage The walls of the Vatreses. Furthermore, it can be performed intravenously as a complementary treatment to endoscopic treatment, especially in the five days after intervention (since they are the highest risk of Resangrage). The choice of one or the other drug for the realization of treatment depends on the resources of each hospital. So in American countries it tends to use Ã ¢ â,¬ Å "octreotidoÃ ¢ â,¬, while in Europe, Ã ¢ â,¬ Å" terlipresinÃ ¢ â,¬ is preferred, both with excellent results. However, it should be noted that Ã ¢ â,¬ â "TerlipresinÃ ¢ â,¬ (a synthetic derivative of Ã ¢ â,¬ Å" vaspressinÃ ¢ â,¬) should be first choice, since it was the unique drug that He has proven to increase survival. The somatostatin, octreotic or a vacation must be used as second-choice drugs. Then we will analyze in detail each of these on drugs in order to obtain a more determined view of its effects and features: vasopressin: vasopressin is a powerful vasconstrictor, especially in vascular splanch territory, so that it causes a considerable reduction Blood flow and portal pressure, as well as a reduction in blood flow of Gastroesophagic collateral, demonstrates the bloodstream measurement of Ã ¢ â,¬ Å "VeoDesÃ ¢ â,¬. Similarly, vasopressin significantly decreases the pressure of Varicose Esophagic veins. The vasoconstrictor effect of vasopressin is not limited to the splanch territory, but it also manifests itself in systemic circulation, causing an increase in blood pressure and a decrease in heart spending, coronary flow and heart rate. These Sisthetic effects are the cause of numerous cardiovascular complications, which constitutes the main disadvantage of vasopressin. Furthermore, treatment with this drug is contraindicated in cardiopathic or hyperthesis patients. Vasopressin must be administered in the form of continuous intravenous perfusion. The initial dose is 0.4 U / min, which increased at 0.6-0.8 U / min if necessary. The treatment is maintained up to 24 hours after receiving the hemostasis. With this therapeutic scheme, bleeding can be stopped at about 50 to 60% of patients. The results of the treatment are evaluated by the absence of hematemesis, the hemodynamic stability, without the need for transfusions and the absence of fresh blood in gastric suction. Many patients can have lower complications such as Ã ¢ â,¬ Å "bradycardiaÃ ¢ â,¬ or Ã ¢ â,¬ ã" extrasistoliaÃ ¢ â,¬, but in 25% of cases complications force to suspend treatment (intense abdominal pain , pulmonary edema, arterial ischemia in the various territories, Ã ¢ â,¬ |). Recently it has been shown that simultaneous administration of nitroglycerin, reduces the negative effects of vasopressin. Terlipressin: as a synthetic derivative of Ã ¢ â,¬ Ã Å "vaspressinÃ ¢ â,¬ (triglicyl-lysina-vasopressin) poses more similarities with said drug, although different advantages that make the drug more indicated for pharmacological treatments. Unlike a â,¬ Ã ¢ vasopreinÃ ¢ â,¬ Ã ¢ â,¬ Ã Å "terlipresinÃ ¢ â,¬ has a longest excess, which allows the administration in the form of intravenous bolus repeated by obviating the need for continuous infusion . He has demonstrated a beneficial effect on the control of acute emorrhagia from varicose esophagic varices, improving control of hemorrhage and survival with respect to placebo. the wise I undertook have also shown to have fewer side effects than Ã ¢ â,¬ Å "vasopreinÃ ¢ â,¬, and also that they are less serious. The most frequent side effect of the use of treatments with Ã ¢ â,¬ Å "TerlipresinÃ ¢ â,¬ to say abdominal pain. While more serious side effects are peripheral or myocÃ¡ddic ischemia that occurs in less than 3% of patients. The intravenous injection of Ã ¢ â,¬ Å "terlipresinÃ ¢ â,¬ to the patient must be started as soon as the existence of digestive hemorrhage varices is suspected. Exceeding treatment with a dose of 2 mg / 4h in the first 48 hours, being maintained up to 5 days at a dose of 1 mg / 4h to avoid retention. The total efficiency of Ã ¢ â,¬ Å "TerlipresinÃ ¢ â,¬ to control acute hemorrhage from VATURES ESOPHAGIC in the first 48 hours is from 75 to 80% and from 67% to 5 days. Ã, â,¬ ã "terlipresinÃ ¢ â,¬ is also effective in the heparorrenal syndrome. So the use of terlipressin can prevent kidney failure that is often precipitated by Varose Hemorrhage. Glypresin: glypresin (triglylicylvasoprein), as Ã ¢ â,¬ å "terlipresinÃ ¢ â,¬, is a synthetic derivative of the vasopressin with prolonged execution, which allows you to administer in 2 mg injections every 4 hours. Furthermore, various studies of the treatments made with Ã ¢ â,¬ Å "GlipresinÃ ¢ â,¬ showed high efficiency (about 80%) and lower side effects compared to the section of vasopressin and nitroglycerin. Although the use of Ã ¢ â,¬ Å "therlipresinÃ ¢ â,¬ is still extended and recommended. The somatostatin: Ã ¢ â,¬ Å "somatostatinÃ ¢ â,¬ has the property to reduce blood flow and the portal pressure without presenting the negative effects of Ã ¢ â,¬ Ã Å" vasopreinÃ ¢ â,¬. Also causing a considerable reduction in the blood flow of the Venice. Treatments with Ã ¢ â,¬ Å "somatostatinÃ ¢ â,¬ can be carried out in the form of continuous intravenous perfusion, at a reason of 250-500 mcg / h, in periods of 24 to 48 hours. Taking into account that the perfusion must be preceded by the injection of an intravenous bolus of 250 UG, which is advisable to repeat up to hemostasis, which is obtained about 80% of cases. However, a treatment can also be developed only in the administration of Ã ¢ â,¬ Å "somatostatinÃ ¢ â,¬ in the form of an intravenous bolus, which causes a decrease in portal pressure and the greatest collateral flower flow of that caused in continuous intravine form . For this reason the administration of an intravenous bolus at the beginning of continuous permanent treatment is recommended and when a recurrence occurs. An initial bolus that can be repeated up to 3 times in the first hour if the hemorrhage is uncontrolled. High dose occupation Ã ¢ â,¬ Ã Å "somatostatinÃ ¢ â,¬ (500 mcg / h) causes greater hemodynamic effect and translates into an increase in clinical efficacy in patients with more difficult bleeding (those with active bleeding in endoscopy of emergency). The biggest advantage of Ã ¢ â,¬ å "somatostatinÃ ¢ â,¬ lies in the substantial absence of complications, which allows you to administer very early, even before emergency endoscopy, and maintaining treatment during longer periods (5 Days), an order to prevent early bleeding repetition. Also, numerous recent studies show that Ã ¢ â,¬ Å "somatostatinÃ ¢ â,¬ is as an emergency sclerotherapy and inconvenience less complications. Similarly, it was demonstrated that Ã ¢ â,¬ Å "somatostatinÃ ¢ â,¬ significantly improves bleeding control compared to placebo or non-active treatment. However, despite the beneficial effect on the control of bleeding, Ã ¢ â,¬ Å "somatostatinÃ ¢ â,¬ does not reduce mortality. Similarly, Ã ¢ â,¬ å "somatostatinÃ ¢ â,¬ has been compared with Ã ¢ â,¬ ã" terlipresinÃ ¢ â,¬, obtaining interesting results as differences were not observed in the failure of control of The The child restraint system, the mortality or the incidence of adverse effects in both treatment groups. Octeotrida: Ã ¢ â ¬ Å OcteotridaÃ ¢ â ¬ is an analogue of the most actions (although this fact is not associated with more durable hemodynamic effects) and with similar effects to this. So, the more doses employed in pharmacological treatments with Ã ¢ â ¬ ¢ â ¬ Å OctootridaÃ are those of 50 mg in an initial intravenous bolus, followed by continuous intravenous infusion of 50 to 100 ug / hour. As in the case of somatostatin Ã Ã ¢ ¬ ¢ â ¬ Å OCteotridaÃ ¢ â ¬ it can be maintained up to 5 days in advance to avoid bleeding. The safety profile of the Ã ¢ â,¬Å OctoootridaÃ ¢ â ¬ is similar to that of a â € œ â ¬ ¢ somatostatin. However, the efficiency of Ã ¢ â,¬Å octeotridaÃ ¢ â ¬ like therapy for bleeding varices esophagic varices is controversial. Since the only existing study in which the Ã ¢ â,¬Å OctoteotridaÃ ¢ â ¬ was estimated as initial treatment, placebo differences were not observed in the initial hemorrhage control. However, randomized and controlled using Ã ¢ â ¬ ¢ â ¬ Å octeotridaÃ associated with the endoscopic treatment showed a significant advantage, reducing the haemorrhagic early recurrence, a hemostatic procedure is not the main purpose of which is the surgical To reach the clogging of bleeding esophagic veins by means of physical pressure exerted by the introduction and inflation of a probe. It 'been a pretty process used in the past with the Ã ¢ â,¬Å probes Sengstake-BlakemoreÃ ¢ â ¬; What has two balls (gastric and esophagic), the first to be influenced on the cardia and the second to compress the varices directly. However, is not the only sensor available to develop this treatment, since we can also use the so-called Linton-NachlasÃ ¢ â ¬; A variety of previous probe that presents the particularity of being equipped with a single large capacity balloon (600 ml), which once breathed in, it's impact on cardiae by continuous traction, with which the circulation is interrupted submucosa, leaving the bleeding exagges varicishes. The effectiveness of both types of probes or balloons is high in obtaining primary hemostasis, around 70-90%. Even if, on the contrary, about half of the cases a relapse occurs after uninsoiling the balloon. The complications of this technique are the aspiration pneumonia and esophageal rupture. Therefore, tamponing esophagic must be used as a temporary measure if hemostasis with pharmacological or endoscopic treatment is not achieved. One else has even a treatment that should only be attempted by experienced and in conditions providing for close surveillance. PORTOSSISTIC DERIVATIONS Like many of the previous treatments, the goal is to reduce the pressure in the portal venous system. By establishing for it bridges connecting portals to regular blood veins in the body vessel. For this purpose, different types of surgical shunts have been developed for the control of varicose bleeding. Classifying power factor correction operations as total, partial or selective operation at the base of its impact on the portal blood flow. So we can talk about: Total shunt in those cases in which the whole portal blood flow is diverted towards the inferior vena cava, being a clear example Ã ¢ â ¬ Å Shunt Portocava TerminolateralÃ ¢ â ¬. It is a set of shunt involving transence of the portal vein, at the level of its bifurcation and the creation of an anastomosis between the ends of the carrier vein and the lateral side of the inferior vena cava, so that it is possible to divert the whole portal flow. partial shunt as surgical alternative whose It is to keep the portal pressure gradients lower than 12 mmHg to prevent varicose hemorrhage occur or continuous. Therefore, a partial decompression of the portal system below this 12mmhg threshold can prevent hemorrhage, maintaining the flower or flow portal hepatopetal. As a result, the partial shunt achieve this goal with the use of a small diameter in small diameter between the upper vein or the upper mesental vein and the lower hollow vein. Selective shunt, as a wire that is used to describe a shunt that selectively decompresses the varicose flow by preserving the portal blood flow. Á, â,¬ Å "shunt splenorrhenal distalÃ ¢ â,¬ was conceived as a selective shunt to avoid the high rate of encephalopathy observed with total shunt. Through this operation, varicose veins are decompressed through short gaustric veins that discharges in the vein stimulate the appetite, whose end is anastomy with the left distal renal vein. A particular case of the portrosistotinase derivations, and more usual rescue mechanisms in the treatment of varicuses esophagic varices is intraepathic or percutaneous transcyugular percutaneous derivation, also known as Tips and in some cases DPPI. A derived treatment in which a calibrated Sisthetic communication is created through the hepatic lounge, from placeing an interventional radiology prosthesis. This controls treatment of vein bleeding in 95% of cases and is the main treatment for refractory hemorrhage varics. With the introduction of Ã ¢ â,¬ Ã ¢ â,¬ Å "ploittrafluoroethylene (PTFE) prosthesis, one of the main drawbacks of suggestions has been solved, which has been the appearance of dysfunction or obstruction. It also seems that the use of these new prostheses does not increase the rate of encephalopathy. Despite the use of tips as rescue treatment raises the inconvenience of its high associated mortality, which is about 35%. Although a medical discussion is established at the point, considering the question that if patients with evil pronounced factors could benefit from a more aggressive therapy from the beginning. In this sense, a randomized study was performed with patients with a high risk of failure (GPVH Á, â € ¥ 20 mmHg) comparing tips with standard treatment. Get results in which patients who performed a series of suggestions presented a lower failure in treatment and less mortality. However, standard therapy enclosed in this study was only endoscopic treatment, and not the current standard (combination of drugs with endoscopic treatment). The therapeutic failure in the control group (patients with GPVH Ã ¢ â € ¥ 20mmhg treated with sclerotherapy) was 50%, much greater than bankruptcy recently observed in patients with GPVH Ã ¢ â € ¥ 20mmhg treated with drugs and Endoscopic treatment, which is about 22%. In view of such progress, you are developing a new multistical study, whose purpose is to clarify if the tips is better than combined therapy for the treatment of high-risk patients. Finally, it is to be reported as derivative surgery reaches rates similar to tips in the control of bleeding, but this is applicable only in patients with good liver function (according to the Child-Pugh scale, patients with a result

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