Ascites

Ascites is the excessive accumulation of fluid in the abdominal cavity. For fluid to be detectable by clinical examination there has to be at least 1500 ml present (slightly less in a small, thin person, but significantly more in an obese person). Ultrasound can detect much smaller volumes (≤500 ml). Ascites that is not infected and not associated with hepato-renal syndrome may be graded as follows:[1]

- Grade 1 is mild ascites and is only detectable by ultrasound examination.
- Grade 2 is moderate ascites causing moderate symmetrical distension of the abdomen.
- Grade 3 is large ascites causing marked abdominal distension.

Refractory ascites can be divided into two groups:

- Diuretic-resistant ascites is refractory to dietary sodium restriction and intensive diuretic treatment for at least one week.
- Diuretic-intractable ascites is refractory to therapy due to the development of diuretic-induced complications that preclude the use of an effective dose of diuretic.

Causes of ascites

- Cirrhosis:
  - Ascites is the most common manifestation in cirrhotic patients and is associated with a reduced survival rate.[2]
  - Approximately 75% of patients presenting with ascites have underlying cirrhosis and about 50% of patients with cirrhosis will develop ascites over a 10-year period of follow-up.[1]
  - Fluid retention (primarily ascites but also peripheral oedema and pleural effusions) is the most frequent complication of end-stage liver disease. It significantly impairs the quality of life of patients with cirrhosis and is associated with poor prognosis - one-year and five-year survival rates of 85% and 56% respectively.[3]
  - Beware the patient with a very long history of stable cirrhosis who then develops ascites - hepatocellular carcinoma must be excluded.

- Malignancy accounts for around 15%. The usual causes are:
  - Malignancies of the gastrointestinal tract (carcinoma of stomach, colon, pancreas; primary hepatocellular carcinoma and metastatic liver cancer).
  - Carcinoma of ovary: Meigs’ syndrome is a rare complication of ovarian cancer and produces ascites out of all proportion to the size of the tumour and pleural effusions, often unilateral.
  - Metastatic carcinoma within the abdominal cavity.

- Heart failure.
- Nephrotic syndrome.
- Protein-losing enteropathy.
- Tuberculosis.
- Pancreatitis.
- Other rare causes, including hypothyroidism.
- Iatrogenic - eg, ovarian hyperstimulation as a consequence of IVF procedures.
Presentation

- Abdominal distension.
- Weight gain as a result of water retention.
- Discomfort: tense ascites is very uncomfortable but prior to this stage there is simply abdominal distension with only very mild discomfort. Malignancy-related ascites is frequently painful.
- Nausea and appetite suppression: tense ascites presses on the stomach and bowel.
- Increasing dyspnoea: due to limited venous return from the lower limbs (pressure on the inferior vena cava) and impaired expansion of the lungs (pressure on the diaphragm).
- There may be other symptoms related to the cause of the ascites.
- Consider risk factors for liver disease:
  - Alcohol consumption.
  - History of jaundice.
  - History of chronic hepatitis B or hepatitis C (or risk factors for these diseases).
  - Obesity, hypercholesterolaemia and type 2 diabetes mellitus are causes of non-alcoholic steatohepatitis, which can progress to cirrhosis. [4]

Examination

Perform a full abdominal examination.

- Look at the patient, both with them lying down and standing up. The shape of the abdomen often suggests fluid. On lying down, the flanks are full but on standing the fluid accumulates in the lower abdomen.
- The high intra-abdominal pressure may push out an umbilical hernia or even an inguinal hernia.

- There may be stigmata of other diseases. Look for signs of liver disease and cirrhosis including:
  - Jaundice
  - Muscle wasting
  - Gynaecomastia
  - Spider naevi
  - Palmar erythema

- Rarely, a firm nodule in the umbilicus (known as Sister Mary Joseph’s nodule) is found and suggests peritoneal carcinomatosis originating from gastric, pancreatic, or hepatic primaries. A left-sided supraclavicular node, or Virchow’s node, suggests the presence of upper abdominal malignancy.

Examination for ascites
Shifting dullness is used to detect ascites. One study found the **absence** of flank dullness to be the most accurate predictor against the presence of ascites - the probability of ascites without flank dullness was less than 10%. [6]

- Percuss from the level of the umbilicus and repeat moving laterally towards one side.
- When the sound becomes dull, keep your fingers there to mark the spot and ask the patient to move on to the opposite side.
- Wait briefly for the fluid to sink and percuss again. If it is now resonant, that is a positive sign. Percuss down until dullness is reached again.
- Repeat on the other side.
- False positives do occur, probably from dilated coils of small intestine reacting to gravity.
- At least 1500 ml of fluid must be present for a result. An ultrasound scan will detect much less fluid with greater certainty.

Large ascites can be detected by a 'fluid thrill'. This test requires two examiners. One person places the side of the palm of one hand firmly on the centre of the abdomen, with the fingers pointing towards the groin. The second person places the palm of one hand on one flank and then flicks the other flank. In large ascites, a palpable fluid thrill can be felt by the palm resting on the opposite flank.

**Monitoring**

Simple assessment of the progress of ascites may be made by:

- Serial measurements of the abdominal girth - ensure the tape measure is placed in the same position each time.
- Serial measurement of weight - rapid changes indicate fluid gain or loss which are much faster than gain or loss of fat or lean body mass.

**Differential diagnosis**

The differential diagnosis of ascites is with other causes of abdominal mass, especially large cysts, although sometimes plain obesity may seem like ascites. The essential feature is the fluidity and shifting with position.

**Investigations**

The cause of the ascites is often apparent after an adequate history and examination. The aims of investigation for ascites are:

- Confirming the presence of ascites.
- Finding the cause for the ascites.
- Assessing any complication due to the ascites.

**Blood tests**

- FBC
- Renal function tests
- LFTs
- Clotting screen
- TFTs

If cirrhosis is confirmed, further tests will be required to elucidate the cause - eg, antibody tests for hepatitis B or C.
Imaging studies
- Abdominal ultrasound is a very sensitive way of assessing ascites and may also show the causative pathology such as carcinoma of ovary or metastatic liver disease.
- CXR may show pleural effusion, evidence of pulmonary metastases or heart failure.
- If ultrasound has failed to reveal a cause then MRI scanning may be used.

Invasive procedures
See separate Ascites Tapping article.

Management[6]
- Treatment of any underlying cause.
- A diet with salt intake restricted to <90 mmol/day (5.2 g of salt/day) is useful, especially in cirrhosis but is unlikely to be effective in other aetiologies such as malignancy.

Drugs
The first line of management of ascites is medical treatment (sodium restriction and diuretic therapy) and is effective in the majority of cirrhotic patients with non-refractory ascites.

- Diuretics:
  - Spironolactone is the best initial choice in cirrhosis: it increases sodium excretion and potassium reabsorption in the distal tubules. 100 mg/day can gradually be increased to 400 mg as necessary. Serum potassium levels need monitoring, as hyperkalaemia frequently limits spironolactone’s use.
  - Loop diuretics may be used as an adjunct to spironolactone, generally only when maximum doses of the latter have been reached.[1] Start cautiously with, for example, furosemide 40 mg/day, although up to 160 mg/day may be used. High doses cause severe electrolyte disturbance, particularly hyponatraemia.

Therapeutic paracentesis
- Patients with large or refractory ascites generally benefit from therapeutic paracentesis.[1]
- This needs to be a sterile procedure.
- Paracentesis of <5 litres of uncomplicated ascites should be followed by plasma expansion with a synthetic plasma expander.[1]
- Larger-volume paracenteses should be followed by volume expansion using human albumin solution.

Catumaxomab
- Catumaxomab is a trifunctional bispecific monoclonal antibody.[7]
- Studies have found that intraperitoneal catumaxomab has a clear clinical benefit for patients with malignant ascites secondary to epithelial cancers (especially gastric cancer) and is generally well tolerated with an acceptable safety profile.[8]

Surgical
A transjugular intrahepatic portosystemic shunt (TIPS) can be used in patients with refractory ascites needing frequent paracentesis (>3/month). It is a local anaesthetic procedure (with sedation) and has generally replaced surgically created portocaval shunts. Shunts block in about a quarter of cases. The effectiveness of TIPS has been improved by the inclusion of covered stents which improve long-term shunt patency.[9] Trial results are often conflicting as to whether such a procedure offers improved survival as compared with repeated therapeutic paracentesis:

- The most recent Cochrane review on this subject concluded that TIPS was more effective at removing ascites compared with paracentesis; there was no significant difference in mortality, gastrointestinal bleeding, infection and acute kidney injury but patients with TIPS develop hepatic encephalopathy significantly more often.[10]
- Three meta-analyses have all failed to demonstrate a difference in survival between TIPS and large-volume paracentesis groups.[11]

The Model for End Stage Liver Disease (MELD) score can be calculated, which is helpful in determining when the risk/benefit ratio for TIPS is favourable.[12] The calculation involved is quite complex and an online calculator is available to assist.[13]

Palliative care[14]
In malignant ascites, paracentesis, diuretics and shunting are commonly used procedures but robust evidence supporting their use in this palliative setting is lacking.

- Diuretics are helpful in about 40% of cases.
- Paracentesis gives good, although temporary, symptom relief. It can be complicated by hypovolaemia and simultaneous intravenous infusion may be required.
- Shunts can control malignant ascites but there are potential risks entailed and they should only be used where other treatments fail.

Complications...
• **Hyponatraemia** on diuretics.[1]

• Spontaneous bacterial peritonitis (SBP) - see also separate *Intra-abdominal Sepsis and Abscesses* article:
  - This occurs in 10-30% of patients with ascites and has a mortality rate of 20%.
  - It is frequently asymptomatic but most will have some symptom(s) such as fever, mild abdominal pain, vomiting, or confusion.
  - Suspect SBP where patients present with hepatic encephalopathy, renal impairment or peripheral leukocytosis without any obvious precipitating factor.
  - A diagnostic paracentesis is mandatory in all patients with cirrhosis, requiring hospital admission to ensure that it will be detected.
  - Organisms are usually *Escherichia coli*, streptococci and enterococci.
  - Empirical antibiotics should be started if ascitic fluid contains >250 cells/mm³. There is no clear evidence favouring one particular antibiotic but, in practice, third-generation cephalosporins have become the standard treatment for SBP.[15]
  - Prophylactic antibiotics for SBP should be given in certain patient populations.
  - All patients with SBP should be referred for liver transplantation.

• **Hepatorenal syndrome**.[16]

### Prognosis
- Patients with cirrhosis who develop ascites have a one-year mortality rate of 15% and a five-year survival rate of 44%.[17]
- For most patients with cirrhosis, therapeutic paracentesis and TIPS without transplantation may improve quality of life but are not thought to improve long-term survival significantly.
- Malignancy ascites tends to suggest widespread disease and a poor prognosis.

### Further reading & references

5. Runyon B; Management of Adult Patients with Aceses Due to Cirrhosis: Update, 2012.
13. MELD Score (Model For End-Stage Liver Disease) (12 and older).
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