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Research Article

**SEVERITY OF ESOPHAGEAL VARICES AT TERTIARY CARE
HOSPITAL**

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ABSTRACT:

OBJECTIVE: To determine the severity of esophageal varices at tertiary care hospital

PATIENTS AND METHODS: The cross sectional study comprises fifty patients, newly diagnosed with cirrhosis of liver with history of gastrointestinal bleeding were explored and entered in the study. After the detail clinical history, physical examination and relevant investigations all the patients had upper GI endoscopy to evaluate the existence and severity of esophageal varices while the data was analyzed in SPSS and frequency and percentages (%) were calculated.

RESULTS: During six months study period total fifty patients of liver cirrhosis with upper GI bleeding had endoscopy having mean age \pm SD was 37.87 ± 6.86 with male gender predominance 64%. Of fifty individuals grade I, II, III and IV esophageal varices was identified in 26%, 44%, 22% and 8% while the Child-Pugh A, B and C was detected in 40%, 34% and 26%. Majority 70% of patients were belonged to rural population and had chronic viral hepatitis C infection 50%.

CONCLUSION: the presence of higher grades of varices and can hence identify the subset of patients who require endoscopy for the prophylactic management of esophageal varices

KEYWORDS: Esophageal varices, Upper gastrointestinal bleeding and Liver cirrhosis

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INTRODUCTION:

Portal hypertension is the result of an expansion in the splanchnic blood stream optional to vasodilation and expanded protection from the section of blood through the cirrhotic liver. Advancement of esophageal varices (EV) is one of the major confusions of entry hypertension [1]. The revealed mortality from first scene of variceal draining extents from 40-70%. In patients with cirrhosis the occurrence of esophageal varices increments by almost 5% every year, and the rate of movement from little to vast varices is roughly 5 to 10 % every year. The danger of variceal burst is most noteworthy in the 2 years following conclusion [2]. The American Association for the investigation of liver illness expressed that all cirrhotic patients ought to be screened for the nearness of oesophageal varices when portal hypertension is analyzed. As of late, the Baveno III accord meeting on portal hypertension prescribed that all cirrhotic patients ought to be screened for the nearness of oesophageal varices when liver cirrhosis is diagnosed [3]. Refresh endoscopy is prescribed at two to three years interims in patients without varices and at one to two years interim in patients with little varices to assess the improvement or movement of varices [4]. Nonetheless, this approach has two noteworthy restrictions. Endoscopy is an intrusive methodology & besides the cost adequacy of this approach is likewise questionable, as it were 10-35% patients with cirrhosis are found to have varices on screening endoscopy [5]. It may in this way be more financially savvy to routinely screen patients at high hazard for the nearness of varices, in order to decrease the expanding weight and technique expenses of endoscopy units. Certain biochemical, clinical and ultrasonographic parameters alone or on the other hand together have great prescient power for non-obtrusively surveying to predict varices [6]. Distinguishing proof of non-obtrusive indicators of oesophageal varices will empower us to do upper GI endoscopy in those gatherings of patients, accordingly keeping away from pointless intercession and in the meantime not missing the patients at danger of dying [7]. Generally, the most widely recognized consequence of these investigations was

that parameters specifically or by implication connected to gateway hypertension, for example, splenomegaly and diminished platelet check were indicators of the existence of esophageal varices. Thus the first part of this study comprises the frequency and severity of esophageal varices and second part which will be published later on is consist of predictors of esophageal varices at tertiary care hospital.

PATIENTS AND METHODS:

The cross sectional study comprises patients of liver cirrhosis of ≥ 18 years, either gender presented with upper gastrointestinal bleeding at tertiary care hospital will be further evaluate for esophageal varices by upper GI endoscopy while the exclusion criteria of the study were patients with hematological disorders, DIC, hereditary anemia and upper GI bleeding due to any other cause, individuals having fever associated with thrombocytopenia and the subjects already on medications which are associated with low platelet were excluded. The specific clinical history was taken, relevant physical examination was carried out and management protocol was planned accordingly. The upper gastrointestinal endoscopy will be performed to detect the presence of esophageal & gastric varices and grading them according to endoscopic grading of esophageal varices after taking consent from the patient / next to kin. The data was collected on pre-structured proforma while the frequency and percentages were calculated whereas the mean \pm SD was calculated for numerical variables.

RESULTS:

During six months study period total fifty patients of liver cirrhosis with upper GI bleeding had endoscopy having mean age \pm SD was 37.87 ± 6.86 with male gender predominance 64%. Of fifty individuals grade I, II, III and IV esophageal varices was identified in 26%, 44%, 22% and 8% while the Child-Pugh A, B and C was detected in 40%, 34% and 26%. Majority 70% of patients were belonged to rural population and had chronic viral hepatitis C infection 50%. The results are presented in Table 01.

TABLE 01: THE DEMOGRAPHICAL AND CLINICAL PROFILE OF THE STUDY POPULATION

Parameter	Frequency (N=50)	Percentage (%)
AGE (yrs)		
13-19	07	14
20-29	15	30
30-39	18	36
40-49	07	14
50+	03	06
GENDER		
Male	32	64
Female	18	36
DURATION OF LIVER CIRRHOSIS (yrs)		
≤1	22	44
>1	28	56
SEVERITY OF Liver cirrhosis		
Child-Pugh A	20	40
Child-Pugh B	17	34
Child-Pugh C	13	26
CHRONIC VIRAL HEPATITIS		
Hepatitis B	17	34
Hepatitis C	25	50
Both	08	16
ESOPHAGEAL VARICES (GRADES)		
I	13	26
II	22	44
III	11	22
IV	04	08

DISCUSSION:

Severe upper gastrointestinal seeping as an intricacy of portal hypertension in cirrhotic population. Due to the expanding predominance of chronic liver illnesses, variceal discharge is related with huge morbidity, mortality and social insurance costs [8]. Various examinations have exhibited the viability of beta-blockers for essential counteractive action of variceal bleeding in patients with high-hazard varices showing the significance of screening for the existence of EVs [9, 10]. American association for

the study of liver illnesses expressed that screening esophagogastroduodenoscopy (EGD) for the analysis of esophageal and gastric varices is prescribed when the conclusion of cirrhosis of liver is made by the AASLD rules. Baveno IV accord meeting on portal hypertension prescribed that all cirrhotic patients ought to be screened for the existence of esophageal varices when liver cirrhosis is analyzed [11]. Thusly, there is a specific requirement for a non obtrusive indicator for the existence of EVs to facilitate the medicinal, social and monetary weight of the illness

[12]. Numerous past examinations have reported great prescient estimation of different non-endoscopic factors for the existence or non existence of varices [13]. In our survey we thought about just straightforward, usually accessible, reproducible parameters. Varices in the long run create in all patients with liver cirrhosis and they tend to increment in measure with time and furthermore have expanded shot of dying [14]. We additionally know that the predominance of varices is higher in decompensated than compensated liver cirrhosis and that huge varices have a higher penchant to seep than little varices [15]. At a given point in time, an extent of liver cirrhosis individuals particularly the ones with remunerated sickness / compensation disease won't have varices. Diagnosing EVs by non intrusive means would confine the execution of endoscopy in patients with a high likelihood of having varices at some superior health centers and in developed countries. In current series, out of fifty individual the grade I, II, III and IV esophageal varices was identified in 26%, 44%, 22% and 8% while the results are consistent with the former studies [16, 17].

CONCLUSION:

The presence of higher grades of varices and can hence identify the subset of patients who require endoscopy for the prophylactic management of esophageal varices

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