Case 5

- A 55 years old male patient was admitted to the hospital complaining of abdominal distension and indigestion for 3 wks. ago.
- He gave history of diuretic medication 1 yr. ago, but the last 3 wks. there was week diuresis and increase abdominal enlargement, and edema of his LL.
- Abd. exam.: liver not palpable, splenomegaly, ascites

Case 5

- **US: cirrhotic liver, splenomegaly and ascites.**
- **Lab. Results:**
- **Serum albumin : 2.5 gm/dl**
- **AST : 68 IU/ml**
- **ALT : 46 IU/ml**
- **INR – 1.5**
- **Total bilirubin - 1.2 mg/dl**
- **Serum creatinine - 1.0 mg/dl**
- **WBC – 4200 - Platlets - 94,000**
- **Hb% : 12.5 gm/dl - Anti-HCV : +ve**

Case 5

- A diagnostic paracentesis was performed; fluid analysis showed:

Ascitic fluid protein – 1.3 gm/dl
Ascitic fluid albumin – 0.7 gm/dl
WBC – 1150/mm3
Polys 75%
Mononuclear cells - 22%

- Calculated serum/ascites albumin gradient (SAAG):

  2.5- 0.7= 1.8

  (High SAAG ascites) consistent with portal hypertension

- Spontaneous bacterial peritonitis (neutrophil count >250)

Case 5

- As Portal hypertension is associated with bacterial translocation (BT) and innate immune activation in cirrhosis,

- Do pathogen associated and danger associated molecular patterns (PAMPs and DAMPs) have a role in the severity of portal hypertension in this case.

Case 5

- How to manage the case,
- Can we add any novel therapies for portal hypertension acting on these processes?