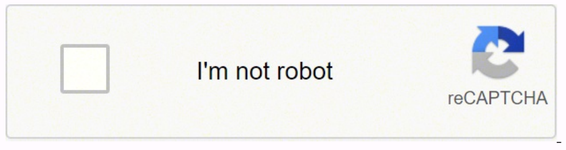
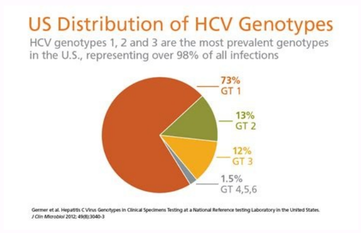
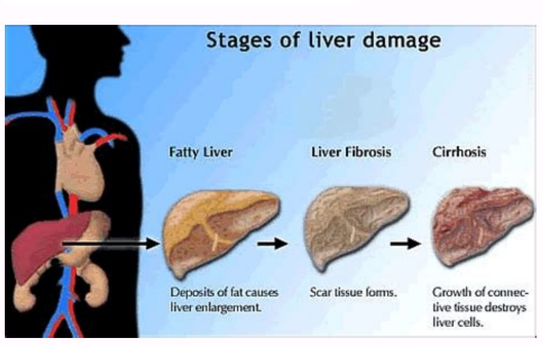


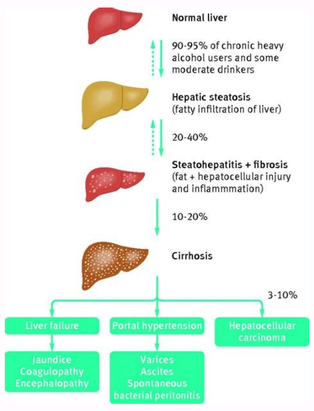
Open

Hcv guidelines decompensated cirrhosis

	COMPENSATED			DECOMPENSATED (CSPH present in all cases)		
STAGE (11)	Stage 1a	Stage 1b	Stage 2	Stage 3	Stage 4	Stage 5
Features	No CSPH No varices	CSPH No varices	CSPH Varices	Variceal bleeding without any other complication	First non-bleeding decompensation (e.g. ascites, HE, SBP)	Any second decompensation (e.g. recurrent variceal Hemorrhage; refractory ascites; HRS; hyponatremia; recurrent HE; Jaundice
1-year Mortality (11)	1.5%		2%	10%	21%	5-year-Mortality: 87%
Progression/ Complications (annual incidence) (11)		7% GEV (Stage 2) 4% Ascites (Stage 4)	4% EV bleeding (Stage 3) 6.6% Ascites (Stage 4)	21% Ascites (Stage 4)	10% further decompensation (Stage 5)	
Aim of therapy (7)	Prevent CSPH	Prevent Varices Prevent decompensation		Prevent further decompensation Reduce mortality		Reduce mortality
Major known risk modifiers	Alcohol intake (27) Ongoing liver injury (e.g. HCV, HBV) (27) Obesity (33)		All previous + HVPG response to NSBB (39-41)	Liver and renal function (5) HVPG response to NSBB (39-41) Alcohol intake Sarcopenia (34) Vitamin D deficiency (35)		
Evidence-based therapy	Etiologic Rx (27) Stop alcohol (27) Consider lifestyle changes (45) Consider Statins (47-52)		All previous + NSBB or Carvedilol (7; 27) Consider Statins (47-52)	Acute episode: vasoactive drugs + EVL + antibiotic proph. + avoid overtransfuse (7; 27) Prevention of rebleeding: NSBB+EVL+ Statins (53) Early TIPS in high risk patients (64;65) Nutritional therapy Consider OLT	Ascites (6): standard medical therapy+/-LVP; prophylaxis of SBP in high risk patients; weekly i.v. Albumin+ standard medical therapy: new approach? (59) SBP: Targeted antibiotic therapy; prophylactic antibiotics after a first SBP episode (6;8) HE: Rifaximin (56) Nutritional therapy Consider OLT	Recurrent or refractory ascites (selected patients), recurrent bleeding: TIPS (6; 7; 66) HRS: Terlipressin +Albumin (6) Ascites in Child C: Norfloxacin (62) Nutritional therapy Consider OLT







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Notably, 100% SVR12 Â was achieved in the small number of genotype 5 patients (n = 5) and genotype 6 patients (n = 6) with compensated plywood enrolled in ASTRAL-1. Ascitis persisted in 48.6% and encephalopathy in 30.5% of patients at the time of delisting, indicating that in some patients significant morbidity may persist over the long term despite SVR (Bittermann, 2020). Real cohort studies have reported rates of SVR in patients with decompensated cirrhosis. Serious adverse events were reported in 16%-19% of treated patients. Unless your diseased liver can be replaced with a healthy liver (liver transplant), you may then die from complications of life-threatening liver disease. MELD scores improved in 42% of treated patients and worsened in 11%. At week 12, 47% of patients had an improvement in CTP score, 42% had no change, and 11% had an increase in CTP score. DURATION EVALUATION RECOMMENDED Genotype 1, 4, 5 or 6 only: fixed daily combination of ledipasvir (90 mg) /sofosbuvir (400 mg) with a low starting dose of ribavirin (600 mg, weight-tolerated dose increase) is 12 weeks I, Ab Genotype 1-6: Combin fixed daily dose of sofosbuvir (400 mg) /velpatasvir (100 mg) with ribavirin by body weight 12 weeks I, Ad a Includes CTP patients with Class B and C who may or may not be candidates for liver transplantation, including those with hepatocellular carcinoma. Twenty-two subjects experienced virological failure, including 20 relapsed patients and 2 patients (genotype 3) with on-going virological breakthroughs. The most common adverse events were asthenia, headache and pruritus. The frequency of serious adverse events and the need for early treatment discontinuation were low in both treatment groups. It is not known whether this reduction in SVR can be overcome with a prolonged duration of therapy. In a Japanese phase 3 study, Conducted in patients with CTP B (77%) and C (20%) cirrhosis 102 patients with genotype 1, 2 or 3 were randomized to 12 weeks of sofosbuvir/velpatasvir, with or without ribavirinÃ (Takehara, 2019). TO 2, Nonradomised, the open label study of Elbasvir / Grazoprevir (50 mg / 50 mg) for 12 weeks Ã was completed in 30 genotype 1 patients with class B CTP cirrhosis (Jacobson, 2019). Most patients received a dose of ribavirin of 600 mg/d. Therefore, Paritaprevir / Ritonavir / Obitasvir Â± Dasabuvir Ã is contraindicated in all patients with decompensated cirrhosis due to concerns about hepatotoxicity. Start here: Choose a patient profile from the menu above. The overall SVR12 rates were 97% (34/35) in genotype 5 patients and 100% (41/41) in genotype 6 patients. As expected, the frequency of serious adverse events Ã¨ increased with the duration of treatment of both CTP GROUP CLASS B (10%, 12 weeks; 34%, 24 weeks) and the CTP Group Class C (26%, 12 weeks, 42%, 24 weeks). Rates of SVR among the 12 patients with CTP Class B Cirridosis and genotype 2 were 100% (8/8) with Sofosbuvir / Velpatasvir for 12 weeks (with or without ribavirin) and 75% (3/4) with Sofosbuvir / Velpatasvir for 24 weeks. All participants had a hemoglobin level > 10 g/dl and an EGFR Ã¢ Â¥ 50 ml/min/min (curry, 2015b). The distribution of the genotype/subtype of participants Ã¨ was 60% (159/267) genotype 1a; 18% (48/267) genotype 1b; 4% (12/267) genotype 2; 15% (39/267) genotype 3; 3% (8/267) genotype 4; and

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