



Could TIPS be Applied in All Kinds of Portal Vein Thrombosis: We are not Sure!

Dear editor:

We read with interest the recent article by Chinchilla-Lopez, *et al.* regarding the role of transjugular intrahepatic portosystemic shunt (TIPS) in patients with refractory ascites and portal vein thrombosis (PVT).¹ We should applaud their work for the extend of TIPS indication in this population, since high-quality clinical trials has demonstrated that patients with refractory ascites and/or PVT could benefit from this procedure.^{2,3} However, several issues need further clarification.

A reduced portal flow velocity has shown to be an important underlying mechanism of PVT formation in patients with cirrhosis.⁴ TIPS creation could restore portal vein flow, recanalize portal venous system and relieve the complications of portal hypertension. However, the intrahepatic PVT (such as the case presented by Chinchilla-Lopez) couldn't resolve because the intrahepatic portal branch flow was further decreased after TIPS.¹ The TIPS indication in patients with intrahepatic PVT need further evaluated.

A post-TIPS portosystemic pressure gradient (PSG) below than 12 mmHg was usually considered the target threshold of *de nova* TIPS creation.⁵ It is uncommon for the authors to report pre- and post-TIPS portal pressure instead of PSG.¹ In addition, a significant low post-TIPS PSG may lead to deprivation of portal perfusion, aggravated liver function and increased incidence of hepatic encephalopathy.

Xuefeng Luo, Li Yang

Department of Gastroenterology and Hepatology,
West China Hospital, Sichuan University, Chengdu, China.

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CONFLICTS OF INTEREST

The authors disclose no conflicts.

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Reply

We appreciate your interest and comments of our work published in *Annals of Hepatology*. It is well known that Transjugular Intrahepatic Portal Shunt (TIPS) is a good alternative for management of complications of portal hypertension. However, nowadays the management of

intrahepatic portal thrombosis is a controversial subject due to the lack of evidence and the challenge it represents. We believe that our case was handled in a correct manner supported by global recommendations and guidelines.^{1,2} According to Rössle, *et al.*,³ TIPS-based therapy was sustained in our patient due to the following reasons: The failure of anticoagulant therapy and the lack of response to drugs of its refractory ascites.⁴ Moreover, this therapy could be a protective factor for the refractory bleeding.^{5,6} Furthermore, our patient was candidate for liver transplantation and it is well known that TIPS placement has demonstrated to be useful for decreasing the complications of patients awaiting liver transplant. In these cases, TIPS procedure has been used as a bridging therapy to allow them to remain on the transplant list longer and reduce patient dropout.^{7,8} Perhaps subsequent measurements of portal venous pressure had needed to verify the portal vein pressure of our patient. Finally, we believe that the management of our patient is supported by the current recommendations of AASLD and EASL for the use of TIPS.^{2,4}

Paulina Chinchilla-López, Oscar Ramírez-Pérez,
Vania Cruz-Ramón, Nahum Méndez-Sánchez.

Liver Research Unit, Medica Sur Clinic & Foundation,
Mexico City, Mexico.

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