PROCEDURE: S-03	Title: *Ascites*

Type: Clinical Procedures
Subsection: S- Special Services
Authority: Executive Director with Medical Director
Related Documents:

Policy

Ascites is the accumulation of fluid within the peritoneal cavity and develops in 15-50% of patients with malignancies as well as in other non-malignant disease processes such as cirrhosis of the liver. This guideline does not address disease specific approaches in the management of ascites.

S-03.01 Assessment

1. Abdominal pressure, pain.
2. Anorexia, early satiety, nausea, vomiting.
3. Dyspnea and/or orthopnea.
4. Increased abdominal girth.
5. Peripheral edema.
6. Reduced mobility.
7. Reflux esophagitis.
8. Shifting dullness to percussion and a fluid thrill.

Ascites is often an indicator of limited life expectancy with exception of some malignancies such as ovarian cancer and lymphoma if they respond to systemic treatments. It may give rise to severe increased intra-abdominal pressure and distension with discomfort and pain, esophageal reflux, nausea, dyspnea.

S-03.02 Underlying Causes

1. Management should include treating reversible cause (s) where possible and desirable according to the goals of care. The most significant intervention in the management of ascites is identifying underlying cause(s) and treating as appropriate.
2. While underlying cause(s) may be evident, treatment may not be indicated, depending on the stage of the disease. Identifying the underlying etiology of ascites is essential in determining the interventions required.

S-03.03 Causes

1. Hypoproteinemia.
2. Alcoholic Cirrhosis.
3. Malignancy.
4. Peritoneal disease.

5. Peritonitis (medical emergency).
6. Lymphatic obstruction (abdominal and retroperitoneal masses).
7. Raised portal pressure (cardiac failure, IVC obstruction or thrombosis, cirrhosis, liver metastases).
8. Chronic Pancreatitis.
9. Hepatitis.
10. CHF.
11. Non-Hodgkin's Lymphoma.
12. Etc.

S-03.04 Education

Patient and family education about ascites should comprise of what to expect with ascites, symptom management approaches, and the importance of communicating any pain or discomfort.

S-03.05 Non-Pharmacological Management

1. Observation is appropriate when the condition is asymptomatic. Observation.
2. Paracentesis is the draining of ascitic fluid via a catheter inserted through the abdominal wall. Generally, upwards of 5 liters of fluid may be removed with little risk of hypotension or hypovolemic shock when patient screening is applied.
3. Peritoneal catheters (a smaller bore catheter) may be useful when ascites is rapidly accumulating and requiring frequent paracentesis for symptom control. This significantly exposes the patient to the risk of peritonitis and is usually reserved for patients in the terminal phase of their illness, with a prognosis of weeks.
4. Salt restriction plays an important role where fluid is transudative but may also provide relief in patients with cancer and hepatic metastases. If the patient still wishes food with salt upon explanation of outcomes, wishes should be honored.

S-03.06 Pharmacological Management

1. Furosemide 40 to 120 mg daily may be added to spironolactone to improve the effect and prevent hyperkalemia. Furosemide given by continuous infusion is reported to produce significant diuresis and marked relief of ascites
2. Octreotide in doses of 200 to 600 mcg S.C. per day has shown promise in cases of ascites refractory to paracentesis.

S-03.07 Review Cycle

Clinical Policies shall be reviewed in the odd year.

Original Approval:	04-2020
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