PALCARE
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THE JIMMY S BILIMORIA FOUNDATION

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

ASCITES

INTRODUCTION

Ascites is caused by accumulation of fluid in the peritoneal cavity. Ascitic fluid can be transudate (protein level less than 30g/L in the fluid), or exudate (protein level greater than 30g/L in the fluid).

Exudative ascites are usually found in malignant effusions, infections. Transudative effusions are found in cardiac or renal failure, cirrhosis, liver failure secondary to metastatic liver disease. Liver cirrhosis is the commonest cause; other causes include malignancy, cardiac failure, tuberculosis and renal disease.

Malignant ascites can occur with any cancer, the commonest being gastrointestinal and ovarian cancer, the latter having the better prognosis.

Malignant ascites indicates advanced cancer and is associated with significant morbidity and a poor prognosis.

ASSESSMENT

- Assessment must determine the underlying cause of ascites, effectiveness of treatment and impact on quality of life for the patient and their family (***refer to the Guideline - Symptom assessment***)
- **Symptoms**
  - Distension of abdomen, discomfort, occasional pain
  - Early satiety, anorexia, acid reflux
  - Nausea, vomiting, constipation
  - Breathlessness, orthopnoea
  - Restricted mobility
- **Signs**
  - Flank dullness, shifting dullness, fluid thrill (depending on the amount of ascites) on percussion
  - Increase in abdominal girth
  - Oedema of lower limbs
- **Investigations (If appropriate)**
  - Ultrasonography abdomen – to confirm ascites if doubtful on clinical examination, suspicion of loculated collection

MANAGEMENT

- **Non-pharmacological measures**
  - Paracentesis
    - Written informed consent should be obtained prior to the procedure
    - Use wide bore venflon after administering a local anaesthetic and connect it with a urobag through a sterile drip set under aseptic conditions
    - Blood pressure monitoring and intravenous fluids are required in the presence of hypotension, dehydration or renal failure.
    - Up to 5L of fluid can be removed in a single paracentesis
    - Catheter can be left in place up to 6 hours or until the drainage stops
    - Watch for complications – bowel perforation, peritonitis, leakage from the drainage site, localised cellulitis around the drain site, hypovolaemia (low BP, tachycardia, dizziness), exhaustion and weakness for a day or so after the procedure
    - Indwelling peritoneal catheters can be considered when control of ascites cannot be achieved with serial paracentesis
    - Attention to skin care is important
    - Paracentesis improves symptoms in the majority of patients; however, at times, it re-accumulates rapidly, particularly if serum albumin is less than 2g/L and, in such situations, repeated drainage is required

- **Pharmacological measures**

  Diuretics:
  - Are helpful in transudative ascites if renal function permits their use
  - Can be considered particularly if prognosis is more than 4 weeks
    - Spironolactone is the diuretic of choice
    - Frusemide - initial use of a loop diuretic may speed clinical response but should be reduced and discontinued after a satisfactory response is achieved

	Spironolactone	Furosemide (Loop diuretic)
Day 1	100-200mg OD	-
Day 7	200-300mg OD*	40mg
Day 14	200mg 1-1-0	80mg**
* Max dose: 400-600mg sometimes needed ** Max dose: 160mg		

  - Substantial reduction may not be seen for 10-28 days
  - Monitor electrolytes

- Note possible interaction with drugs such as digoxin and NSAIDS
- Stop if :
  - no satisfaction response
  - renal impairment
  - not tolerated

References

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