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Comments on the review article: Ascites in cirrhosis: a review of management and complications

Dear Sir,

We read with great interest the comprehensive and up-to-date review article by Kuiper *et al.* entitled Ascites in cirrhosis: a review of management and complications.[1]

We feel that a few points need further clarification. The serum-ascites albumin gradient (SAAG) threshold level of 11 g/l is an indicator of portal hypertension (with an approximate accuracy of 97%) and not a 'hepatic cause of ascites'.[2] Certainly cirrhosis and alcoholic hepatitis are 'hepatic causes' but we are not sure that we can classify cardiac failure, myxoedema or portal vein thrombosis (all associated with SAAG >11g/l) as such. SAAG in other words is not a pathogenesis identifier test. It simply provides the clinician with an accurate, indirect estimate of the portal pressure.[3]

The authors classify as 'useful' tests of the ascitic fluid the cell count, amylase, triglyceride concentration, chylomicrons and in 'selected cases cytological and immunological examination'. It is, we believe, unfair to group together tests that come into different stages of the ascites investigation algorithm, if at all.

The cell count is the single most useful test for ascitic fluid. Runyon suggests that the practice of ordering every available fluid test on every paracentesis can be counterproductive and if only drops of fluid can be obtained, they should be sent for cell count.[3] Furthermore, he suggests that on the basis of cost analysis the ascitic fluid tests can be classified as routine (cell count, albumin and total protein), optional (culture in blood culture bottles, glucose, LDH and amylase) and unusual (cytology, triglyceride, bilirubin and TB smear).[3] Kuiper *et al.* have not mentioned the use of leucocyte esterase reagent strips (dipsticks) in the bedside screen for SBP. Several studies suggest that they can be used to shorten the tap-to-antibiotic time, especially in out-of-hours paracenteses.[4]

The Ricart *et al.* study to which the authors refer (reference 48 in the original article) used amoxicillin/clavulanic acid every eight hours and not four times daily.[5] Most authorities suggest an initial dose of spironolactone at 100 mg (50 mg is probably inadequate for moderate ascites),[3] and a recently reported study suggests beneficial effect of albumin in the group of patients with SBP and bilirubin >64.8 µmol/l, and creatinine >88.4 µmol/l.[6]

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