

Timing of Treatment for Budd–Chiari Syndrome: Still an Open Issue



I read with interest the paper published in *Journal of Clinical and Experimental Hepatology*, reporting data on 138 patients with Budd–Chiari syndrome (BCS) who were treated with medical therapy alone, including anticoagulation, of whom 55% had complete response (CR), 18% partial response (PR) and 26% no response (NR). None with PR or NR had CR later. Moreover, at a median follow-up of 40 months, lost of response (LoR) was more common in the PR group than in the CR group and was significantly associated with the presence of ascites at presentation. Furthermore, mortality was higher in NR compared with CR and PR. Anyway, the all-group 10-year survival was only 33%.¹

Overall, the results of this study forcefully enter the debate about timing of interventional treatment for BCS.^{1,2} Actually, there are two main trends for BCS management, both lacking formal validation, because of the rarity of BCS. The most popular indication for BCS management is the so-called step-by-step strategy, suggesting medical therapy as first line, revascularization or transjugular intrahepatic portosystemic shunt if no response to medical therapy, and liver transplant as rescue therapy.³ However, controversies exist about the management of BCS. In fact, the step-by-step strategy is based on arbitrary criteria requiring validation and is not evidence based. Moreover, the present study, together with a previous one, suggests that only medical therapy results in survival of only one-third of the cases after long-term follow-up.^{1,4} Consequently, a real alternative to the step-by-step strategy is the so-called Early Interventional Treatment strategy, proposing that intervention, in the presence of any sign of portal hypertension, could improve outcome.⁵ In fact, following the latter strategy, excellent survival was reported both in East and West.^{6,7} Anyway, it is noteworthy that for both strategies, ascites not rapidly responding to medical therapy is a clear indication for further intervention.^{3,5}

However, as the present study confirms, in real life, BCS management is not ruled by a sharp indication but follows different attitudes.

Consequently, identifying which subgroup of patients could safely go on sole medical Therapy and which one could benefit early intervention is a crucial issue for the management of BCS. Recently, liver stiffness (LS), a noninvasive estimate of liver fibrosis, although previously considered inappropriate for BCS because of liver conges-

tion, was reported as a promising tool to predict the outcome for BCS on sole medical therapy,⁸ but further data are needed for confirmation.

Finally, the present considerations are furtherly complicated by geographical differences about BCS regarding both etiologies and management.^{9,10}

In conclusion, further data are needed to define the optimal timing of BCS treatment.

Due to ongoing absence of critical clinical factors, a comparison between traditional management with early interventional treatment should be advised.

CREDIT AUTHORSHIP CONTRIBUTION STATEMENT

Author declares that he is solely responsible for the paper.

CONFLICTS OF INTEREST

None.

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<https://doi.org/10.1016/j.jceh.2022.06.006>

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11 June 2022.