Anticoagulation and Budd-Chiari syndrome

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To the Editor,

We read with interest the article by Shukla and Bhatia [1] in a recent issue of the *Journal*. The authors found that 6 of their patients could not undergo the standard radiological procedures because of technical reasons; reasons for this technical failure were however, not provided. In our experience of adult patients, the TIPSS procedure is usually possible. Of 58 patients who underwent TIPSS, we faced technical difficulty in only one patient who had acute Budd-Chiari syndrome; the massive hepatomegaly caused an increase in distance between the IVC and narrowed portal vein (unpublished data). Technical difficulties usually arise in infants when the vein size is too small for stenting. In 14 children with Budd-Chiari syndrome, we could perform radiological intervention successfully in 11; the procedure failed due to small vessel size in 3 patients [2].

The authors found that those with more severe disease did not do well in the long term with anticoagulation alone. These are precisely the patients who benefit with radiological intervention [3]. We have successfully done TIPSS in a four-year-old child with Budd-Chiari syndrome who presented with fulminant liver failure [4].

The use of anti-coagulation alone in the treatment of Budd Chiari syndrome is a compromise rather than an alternative treatment.

References

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Reply from the authors

We sincerely thank Nagral et al. for their valuable comments and interest in our study [1]. We agree that radiologic intervention is the treatment of choice hepatic venous outflow obstruction (HVOTO); this aspect has been highlighted in the discussion of our paper. We had offered radiologic intervention to all patients with HVOTO.

We agree that most technical difficulties in hepatic vein recanalization occur due to small size of veins in children. The difficulty in adults is due to thrombosis of additional veins. In our patients, the causes were: thrombosis of portal vein with complete long segment thrombosis of all hepatic veins ($n=4$), thrombosis of inferior vena cava (IVC) upto the right atrium ($n=1$), and complete thrombosis of portal vein and IVC ($n=1$). In two of them, the portal vein recanalized over 6 months on anticoagulants, and we were able to successfully perform TIPSS (these patients had been excluded from the analysis). The problem of increased distance between the IVC and portal vein, as mentioned by Nagral et al., was faced by us in 2 patients. We could overcome this by using two stents placed back-to-back.

We reiterate that anticoagulation alone be used as therapy for patients with hepatic venous outflow obstruction only when other options are not feasible.

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