K.L. Rodriguez-Peralta*, J.A. Santiago-Ferrer

Gastroenterología, Universidad Privada San Juan Bautista, Lima, Peru

*Corresponding author at. Universidad Privada San Juan Bautista, Lima, Peru.
E-mail address: luana040402@gmail.com
(K.L. Rodriguez-Peralta).

Response to Rodríguez-Peralta concerning the article ''Evaluation and management of emergencies in the patient with cirrhosis''

Respuesta a Rodríguez-Peralta del artículo «Evaluación y manejo de emergencias en el paciente con cirrosis»

Dear Editors,

We appreciate the interest shown by Rodríguez-Peralta and Santiago-Ferrer in commenting on our article ''Evaluation and management of emergencies in the patient with cirrhosis''. In that review article, our aim was to analyze the available literature on the special management required by patients with liver cirrhosis (LC) in an emergency context. Topics focusing on the initial approach to the patient with decompensated LC, with respect to the evaluation and management of emergencies, were selected in the methodology, all of which were supported by the existing information available in Spanish and English, within the time frame of 1980 and the first trimester of 2021.

Regarding their first comment on the management of hepatic encephalopathy (HE) with nonabsorbable disaccharides, such as lactulose and lactitol, we cited in our review that the initial dose of lactulose recommended by the American Association for the Study of Liver Diseases (AASLD) and the European Association for the Study of the Liver (EASL), the primary international associations, is 25 ml (16.7 g) every 2 h, until achieving at least 2 soft bowel movements, which is the goal for the urgent correction of HE, and that its adequate administration in patients whose neurologic status prevents them from swallowing adequately, or who require airway protection, is carried out through the use of enteral tubes.[1] By specifying the fact that in those cases of severe HE, with the accompanying neurologic status, adequate administration must be guaranteed by the use of enteral tubes, along with our knowledge of the West Haven Criteria, we clearly understand that the recommendation in patients with grade III or IV HE, or patients with any oral route incapacity due to neurologic status, is lactulose administration through a nasogastric tube. No reference to administration via enema as a therapeutic option was made in our article, which was intentional on our part, given the scant amount of high-quality evidence on the subject and the fact that the procedure is not very practical or effective in actual clinical practice. No related evidence has been published since the 1987 article by Uribe et al.[2]

With respect to the observations about nonabsorbable antibiotics, we agree that rifaximin is the only drug currently approved by the Food and Drug Administration (FDA) and that its role is mainly one of adjuvant therapy to a nonabsorbable disaccharide, which we echoed in our article when we described its chief function as ''add-on therapy'' to lactulose, supported in the 2014 AASLD and EASL guidelines (GRADE I, A1).[3] Likewise, Rodríguez-Peralta and Santiago-Ferrer refer to the work by Sharma et al. (described in the article by Reinert et al.) that recommends the combination of lactulose and rifaximin because it achieves greater HE resolution, compared with lactulose alone.[4] It should be pointed out that our article had already been submitted for publication, when the literature review by Reinert was published in December 2021, and that in their original 2013 reference, Sharma et al. concluded that the combination of lactulose plus rifaximin was more efficacious than lactulose alone, in the treatment of overt HE,[5] an assertion that does not change the similar idea expressed in our review. We also cited a systematic review and meta-analysis (that included the study by Sharma et al.), commenting that initial treatment with the combination of rifaximin and lactulose significantly increased clinical efficacy, with a number needed to treat of 5, as well as a decrease in the mortality rate.[6]

We completely agree with adding intravenous (IV) L-ornithine L-aspartate (LOLA) in nonresponders to conventional therapy, which is why we stated in our article that it can be used intravenously, as an alternative or additional agent in such patients, supported by studies showing improvement on psychometric tests and in serum ammonia levels in patients with persistent HE, as well as mortality rate improvement described in a meta-analysis.[1–7] The article referred to by Rodríguez-Peralta and Santiago-Ferrer, in which LOLA improved the grade of HE, reduced the recovery time, and was associated with a lower mortality rate, is indeed interesting, but again, that study came out in 2022, after our review had already been published.

Lastly, it is important to reiterate that the aim of our work was to offer the reader a review of the basic aspects of initial resuscitation of critically ill patients with LC, with a special focus on the evaluation and management of emergencies, and not to concentrate exclusively of the management of HE, given that extensive and specific clinical guidelines on each complication of cirrhosis already exist.

Ethical considerations

The authors declare they have met all ethical responsibilities regarding data protection, right to privacy, informed consent.

☆ Please cite this article as: Velarde-Ruiz Velasco JA. Respuesta a Rodríguez-Peralta del artículo «Evaluación y manejo de emergencias en el paciente con cirrosis». Rev Gastroenterol Méx. 2023;88:192–193.

Authorization by the institutional ethics committee was not necessary, given that no patient anonymity norms were violated nor were any experimental procedures carried out that could put patient integrity at risk.

The authors declare this article contains no personal information that could identify patients.

Financial disclosure

No financial support was received in relation to this article.

Conflict of interest

The authors declare that there is no conflict of interest.

References

1. Velarde-Ruiz Velasco JA, García-Jiménez ES, Aldana-Ledesma JM, et al. Evaluación y manejo de emergencias en el paciente con cirrosis. Rev Gastroenterol Mex. 2022;87:198–215, http://dx.doi.org/10.1016/j.rgmx.2021.11.002.
2. Uribe M, Campollo O, Vargas F, et al. Acidifying enemas (lactitol and lactose) vs. nonacidifying enemas (tap water) to treat acute portal-systemic encephalopathy: a double-blind, randomized clinical trial. Hepatology. 1987;7:639–43, http://dx.doi.org/10.1002/hep.1840070404. PMID: 3301614.
3. Vilstrup H, Amodio P, Bajaj J, et al. Hepatic encephalopathy in chronic liver disease: 2014 Practice Guideline by the American Association for the Study of Liver Diseases and the European Association for the Study of the Liver. Hepatology. 2014;60:715–35, http://dx.doi.org/10.1002/hep.27210.
4. Reinert JP, Burnham K. Non-lactulose medication therapies for the management of hepatic encephalopathy: a literature review. J Pharm Pract. 2021;34:922–33, http://dx.doi.org/10.1177/0897190020953024.
5. Sharma BC, Sharma P, Lunia MK, et al. A randomized, double-blind, controlled trial comparing rifaximin plus lactulose with lactulose alone in treatment of overt hepatic encephalopathy. Am J Gastroenterol. 2013;108:1458–63, http://dx.doi.org/10.1038/ajg.2013.219.
6. Wang Z, Chu P, Wang W. Combination of rifaximin and lactulose improves clinical efficacy and mortality in patients with hepatic encephalopathy. Drug Des Devel Ther. 2018;13:1–11, http://dx.doi.org/10.2147/DDDT.S172324.
7. Goh ET, Stokes CS, Sidhu SS, et al. L-ornithine L-aspartate for prevention and treatment of hepatic encephalopathy in people with cirrhosis. Cochrane Database Syst Rev. 2018;5:CD012410, http://dx.doi.org/10.1002/14651858.

J.A. Velarde-Ruiz Velasco*

Servicio de Gastroenterología, Hospital Civil de Guadalajara Fray Antonio Alcalde, Guadalajara, Jalisco, Mexico

*Corresponding author at: Calle Mariano Bárcenas 1164, Colonia Miraflores, C.P 44260, Guadalajara, Jalisco, Mexico. Tel.: 3312228507.
E-mail address: velardemd@yahoo.com.mx

Magnet ingestion knows no borders: A threat for Latin American children, aspects not considered in the study

La ingestión de imanes no conoce fronteras: una amenaza para los niños latinoamericanos, aspectos no considerados en el estudio

After analyzing the article, ''Magnet ingestion knows no borders: A threat for Latin American children'',[1] we wish to share some of our observations.

The title is not precisely specific to the material and methods employed. Forming a very generalized idea through limited information from a few countries, the present work expresses it as a single concept of an entire continent. We feel it is overly ambitious and erroneous to attempt to create a general idea of Latin America, when there are aspects that could be more deeply explored, such as the specialists consulted, the number of countries, and socioeconomic levels, among other inclusion z criteria we will detail below.

With respect to the first point, we can see how a consensus is arrived at from the ideas and contributions of gastroenterology and endoscopy specialists from different countries, but we also believe the work of sonographers should be included, given that the majority of cases are emergencies, and a specialist is not always available, whether because of the type of healthcare center or due to some other factor. In contrast, sonography is a much more accessible procedure that can be performed quickly, and because it is not an invasive method, like endoscopy, it can be more tolerable for a child.[2]

Next, the socioeconomic and cultural levels should be taken into account as variables of interest because they can affect the health of the child in different ways. The socioeconomic level is reflected in the area of residence (which may be far from a medical center, the family may not have the resources necessary for getting to a center quickly, or due to economic limitations the advantage of choosing a center is not a possibility, making the closest center the only option) or in the money available (having insurance or not) for paying for the necessary procedures and tests. Culturally, the educational level of the child's parents can have a notable influence on how quickly it is understood that magnet ingestion is a medical emergency and must be treated as quickly as possible.[3]

In addition, the mental health status of the child should be considered in the inclusion criteria, given that a child with an intellectual disability requires special care, different from that of a healthy child. Even though it is a small group of patients in whom foreign body ingestion is volun-

☆ Please cite this article as: Llanco-Albornoz LA, Mancini-Olaechea AR, Levano-Cerna PC. La ingestión de imanes no conoce fronteras: una amenaza para los niños latinoamericanos, aspectos no considerados en el estudio. Rev Gastroenterol Méx. 2023;88:193–194.
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