MANAGEMENT OF ASCITES

PARACENTESIS GUIDELINES

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Rationale:

The incidence of Ascites in palliative care patients is high due to combination of reasons e.g.,

*Underlying Malignancy
*Associated Liver disease
*Concomitant disorder e.g., Hear Failure

General Principle:

Ascites should be aspirated to palliate symptoms only. Non-symptomatic Ascites are not uncommon and do not warrant active aspiration.

Symptoms:

1. Abdominal distension causing discomfort and pain
2. Dyspnoea
3. Nausea and vomiting

Diagnosis:

Malignant Ascites causing symptoms should be clinically detectable with Fluid thrill, Shifting dullness etc.

If not clinical detectable, unlikely to be the cause of symptoms, Consider other causes e.g., Hepatomegaly, disease process, intestinal obstruction etc.

Ultrasound Scan is helpful in detecting Ascites if there is doubt on clinical examination. It also helps in detecting ‘pockets’ due to adhesions (commoner in TB peritonitis, but can be seen in Malignant Ascites)

Cautions:

1. Reluctant/Non cooperative patient
2. Procedure should be carried out by experienced doctor
3. Coaggulopathy
4. Liver or Renal Failure
5. Infection (local or systemic)
6. Moribund Patient

Procedure:

1. Admit the patient if doing it for the first time on this particular patient
2. Confirm Ascites clinically
3. Check FBC (for platelets), Clotting Profile, LFT (for serum albumin)
4. Explain the procedure
5. Take consent (verbal consent with one professional witness e.g., nurse is valid)
6. Stop diuretics on the morning of procedure
7. Ask the patient to pass urine prior to the procedure
8. Check BP and weight (abdominal girth is not a reiable measurement due to variable liver size)
9. Ask the patient to lie at the edge of bed in semi-recumbent position
10. Ask the patient to tilt 30 degrees towards the site of aspiration
11. Use Right Iliac Fossa at the Mcburney's point (if suggestion of disease on this side, e.g., massive Hepatomegaly, palpable or H/O cancer on this side, try left side)
12. Check for Ascites clinically, again!
13. Aseptic measures
14. Apply local anaesthesia (1-2% lignocaine injectable)
15. Use appropriate needle (e.g., Pleural effusion aspiration needle, grey venflon, Bonanno catheter, pigtail catheter. There is no evidence that one is better than the other)
16. Aspirate actively or leave the tube inside with connection to the drainage bag
17. Do not clamp at any stage (there is evidence that protein rich Ascites causes blockages)
18. If first attempt, stop after 2-3 litres
19. Do not aspirate more than 4 litres in one attempt (there is evidence that cachectic patients with protein rich Ascites are more prone to hypovolaemia/shock)
20. After the procedure, dress with gauze or apply colostomy bag if still tense Ascites
21. Ask the patient to rest in the bed, at an angle of 30 degree to the opposite side
22. Check BP 2 hours after the procedure or before that if patient feels symptomatic
23. Monitor for any complications and request the doctor to review if any concerns

Complications:

Hypovolaemia:

(low BP, exhaustion, high pulse rate)
Volume expanders

Overflow:

Apply guaze, colostomy bag

Follow-up:

BP and weight next morning.
On discharge, ask the patient to monitor weight weekly