		Ascites				
Definition	Accumulation of free	fluid in the peritoneal cavity.				
		Due to local peritoneal conditions as:				
	Exudate	1. <u>Tuberculous peritonitis</u> :				
		2. Malignant ascites.				
		a) Massive, hemorrhagic & rapidly accumulating.				
		b) Malignant cells on aspiration.				
		c) Abdominal mass (tumour) may be felt after tapping.				
		3. Pseudomyxoma peritonii:				
		a) Rupture mucocele of the appendix.				
		b) Burture mucocele of the gall bladder				
		c) Pseudomucinous cystadenoma of the ovary.				
		Portal hypertension Hyperalbumaemia				
	Transudate	1 Circhosis 6 Massive liver meta stasis a Nenbrotic sundrome				
		2 Alcohalic hensitic 7 Congestive heat failure h				
Types		2. Fullyinant honatting 9. Construction participating c. Malautritian				
1,900		4 Subastite O Budd Chari and ano				
		F. Lapatic repairies 5. Dudu- chian syndrome				
		3. hepatic veno-occursive				
	Haemorrhagic	1. Traumatic (especially rupture spieen).				
		2. Malignancy.(most common in HCC in HCV patient)				
		3. Hemorrhagic blood diseases.				
		4. Ruptured ectopic pregnancy.				
		5. Acute pancreatitis.				
	Chylous	Due to thoracic duct obstruction caused by lymph nodes, tumour or filariasis.				
		<u>Features</u>				
		a. Colour: milky white.				
		b. Rich in fat.				
		c. Clears on addition of ether.				
	d. Stains orange with Sudan III					
	Purulent					
Pathogenesis	1. Splanchnic v	rasodilatation is the main factor mediated by nitric oxide, a vasodilator released when portal hypertension causes shunting of				
of ascites in	blood into the	systemic circulation.				
cirrhosis	2. \downarrow Systemic arte	erial pressure $ ightarrow$ activation of renin angiotensin system with secondary aldosteronism, \uparrow sympathetic nervous activity.				
	Portal hyperter	ision.				
	Hypoalbuminer	nia.				
	Aspect	Straw- colored: parenchymal liver disease portal hypertension.				
		Cloudy: Bacterial peritonitis, pancreatitis.				
		Bloody: Trauma, tumor, invasive technique. Blood disease, internal Hag.				
		Green: Biliary tract diseases, ruptured bowel.				
		Milky: Tumor, T.B, Lymph obstruction.				
	Specific gravity	Transudate: between 1005 – 1015.				
Chanastanistis		Above 1015 in cases of evidences				
Characteristic						
of ascetic	Protein	• Transudate: 1-2 g/100 ml.				
fiuld	Frotein	Higher values in: infection, Budd-Chiari syndrome, pancreatitis, I.B, malignant, myxedema, nephrogenous ascites.				
		Lower values in: portal hypertension, hepatic veins occlusion, heart failure.				
		• Polymorphs and peritoneal mesothelium but polymorphs not exceed 100 µL/mm ^{3.} If polymorphs more than 250 µL/mm ^{3.}				
	Cellular	indicates infection.				
	contents	 Red cells: not exceed 1000 µL/mm3, if ↑ indicate hemorrhagic ascites. 				
	Electrolyte	Are those of other extracellular fluid.				
	concentrations					
	History	abdominal distension, dyspepsia , respiratory distress.				
	Inspection	 Diffuse abdominal enlargement with full flanks. 				
		 The umbilings is shifted downwards & everted + hernia 				
		In chronic cases: wide subcostal angle - divarication of recti-				
		White abdominal striae (stria albicans).				
Clinical		Dilated veins on the anterior abdominal wall: may be due to portal hypertension or IVC obstruction				
picture		Fluid transmitted thrill (in tense ascites).				
F	Palnation	 Liver & spleen may be felt by dinning method 				
	i aipation	Abdominal swelling may be felt in malignancy &TB				
		Resonance over the umbilicus & dull flanks (> 21.)				
	Percussion	 Shifting dullness from side to side (> 1.5L) 				
	Auscultation	 Smally dumess non-side to side (~ 1.3L). Knee elbow position (300-500cc) 				
		Puddle sign: in knee ellow position, but the diaphragm on the umbilicus δ coratch from outside towards the umbilicus till				
		$\frac{1}{2}$ using strain where the second probability of the uniformation of the unifor				
		change of tone $\rightarrow +ve = Tiuld$.				
		venous num. may be neard in cases of portal hypertension (renawi sign).				
1	1					

	Clinical picture of the 2ry effects of ascites:					
	1. Right-sided pleural effusion.					
Clinical	2. Elevation of the diaphragm causing:					
picture	a. Congested neck veins.					
	b. Shift of the apex of the heart upwards & outwards.					
	3. Edema follo	wing ascites (in LCF)				
		Pleural effusion usually ranges from 0.	4% to 10%. 60% is right	sided.		
	Bilateral effusion and left sided one is less frequently.					
		If left sided effusion develops alone, T.B is suspected.				
	Hydrothoray	• <u>Causes of effusion:</u>				
	Ingulotitorax	a) nypoaibuillena b) Plasma leakage from a hypertensive azvgous venous system				
		c) Lymph leaking from thoracic duct.				
		d) acquired diaphragmatic def	ects			
Complications		e) Co-existence of other disease as : Meig's syndrome, and congestive heart failure.				
	Spontoneous					
	bacterial	The source of infection can not usually	identified	n sounds à lever in patient with cirmosis à ascites.		
	peritonitis	The source of infection can not usually identified. Escherichia coli is the organism most frequently found				
		Escrenchia con is the organism most inequently found. The condition should be differentiated form other intra abdominal emergencies				
		 Treatment with cefotaxime should be started immediately & recurrence is common 				
	Hernia	Due to ↑ intra abdominal pressure: inguinal,	umbilical			
	Varicose	Due to compression of venous return of lower limbs and the testicle.				
	veins					
	Urinary	As urgency, \uparrow urinary tract infection, difficulty	up to retention of urine			
	1. Obes	ity: due to fat.	4. Pregnant u	terus: due to massive amniotic fluid.		
Differential	2. Diste	nsion: due to gas	5. Ovarian cys	sts: huge		
diagnosis	3. Full u	ırinary bladder	6. Large pancreatic cyst.			
Mallanant			7. Huge organ	no megaly: huge liver and spleen.		
ascites	Rapidly accu Macroscopi	umulated	High lactate dehyd Gutalagical Evu rou	drogenase and cholesterol		
4001100	High protein	cally bloody in 10% of cases only	Cytological EX. rev Polyclonal and mo	reals 60-90% mailghant cells		
	1. Abdomina	I Ultrasound is the best particularly in the ob	bese and those with small v	volumes of fluid.		
	2. Serum-Ascites Albumin Gradient					
	SAAG: serum albumin – ascitic fluid albumin (g/dL)					
	 <u>High gradient</u> (≥1.1 g/dL) indicates portal hypertension with <u>97% accuracy</u> 					
	•	<u><i>High gradient</i></u> (\geq 1.1 g/dL) indicates porta	hypertension with 97% a	accuracy		
	•	<u><i>High gradient</i></u> (≥1.1 g/dL) indicates porta <u><i>Low gradient</i></u> (< 1.1 g/dL) indicates absent	I hypertension with 97% a ce of PHT with 97% accura	accuracy acy		
	•	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein	I hypertension with <u>97% a</u> ce of PHT with 97% accura I) and transudative asci	accuracy acy tes (poor <u>accuracy of 56%)</u>		
Investigations	•	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein High gradient	I hypertension with 97% a ce of PHT with 97% accura a) and transudative asci	accuracy acy tes (poor <u>accuracy of 56%)</u> Low gradient		
Investigations	• • 1. Cirrhosis	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein High gradient	I hypertension with 97% a ce of PHT with 97% accura a) and transudative asci	accuracy acy tes (poor <u>accuracy of 56%)</u> Low gradient Tuberculosis		
Investigations	1. Cirrhosis 2. Budd-Chia	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein <u>High gradient</u> ari synd.	I hypertension with 97% accura ce of PHT with 97% accura and transudative asci 1. 2.	accuracy acy tes (poor <u>accuracy of 56%)</u> <u>Low gradient</u> Tuberculosis Malignant		
Investigations	1. Cirrhosis 2. Budd-Chia 3. Veno-occl	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein <u>High gradient</u> ari synd. usive disease reiter	I hypertension with 97% accuration of PHT with 97% accuration of the second sec	accuracy acy tes (poor <u>accuracy of 56%)</u> Low gradient Tuberculosis Malignant Nephrotic synd. Papereatic accies		
Investigations	1. Cirrhosis 2. Budd-Chia 3. Veno-occl 4. Cardiac as 5. Myxedema	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein <u>High gradient</u> ari synd. usive disease scites a	I hypertension with 97% accurates of PHT with 97% accurate) and transudative ascirtation of the second seco	accuracy acy tes (poor <u>accuracy of 56%)</u> Low gradient Tuberculosis Malignant Nephrotic synd. Pancreatic ascites Biliary ascites		
Investigations	1. Cirrhosis 2. Budd-Chia 3. Veno-occl 4. Cardiac as 5. Myxedema	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein <u>High gradient</u> ari synd. usive disease scites a	I hypertension with 97% accurates of PHT with 97% accurate) and transudative ascirtutes ascirtute accurates and the second sec	accuracy acy tes (poor <u>accuracy of 56%)</u> Low gradient Tuberculosis Malignant Nephrotic synd. Pancreatic ascites Biliary ascites Chylous ascites		
Investigations	1. Cirrhosis 2. Budd-Chia 3. Veno-occl 4. Cardiac as 5. Myxedema	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein <u>High gradient</u> ari synd. usive disease solites a	I hypertension with 97% accuration of PHT with 97% accuration and transudative asciration of the second sec	accuracy acy tes (poor <u>accuracy of 56%)</u> Low gradient Tuberculosis Malignant Nephrotic synd. Pancreatic ascites Biliary ascites Chylous ascites		
Investigations	1. Cirrhosis 2. Budd-Chia 3. Veno-occl 4. Cardiac ac 5. Myxedema Bed rest	<u>High gradient</u> (≥1.1 g/dL) indicates porta <u>Low gradient</u> (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein <u>High gradient</u> ari synd. usive disease scites a Helps mobilization of fluid, giving good urina	I hypertension with 97% accura ce of PHT with 97% accura a) and transudative asci 1. 2. 3. 4. 5. 6. ry exertion especially if the	accuracy acy tes (poor <u>accuracy of 56%)</u> Low gradient Tuberculosis Malignant Nephrotic synd. Pancreatic ascites Biliary ascites Chylous ascites re is low salt intake.		
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Investigations	• • • • • • • • • • • • • • • • • • •	High gradient (≥1.1 g/dL) indicates porta Low gradient (< 1.1 g/dL) indicates absen Replaced exudative (>2.5 g/dL total protein High gradient ari synd. usive disease scites a Helps mobilization of fluid, giving good urina Nacl: less than 0.5gm/Day Proteins: 100gm/day, expect if encept Low fat and high carbohydrate. Diuretics Should be given, if weight loss legroup diuretic without adding por To avoid complications of It is aspiration of ascitic fluid from the Indications: 1. Sluggish response to diuretics 2. Poor urinary output 3. Need for more than 160mg of to of spironolactone.	I hypertension with 97% accurates of PHT with 97% accurate) and transudative ascirture ascirture and transudative ascirture ascirture and transudative ascirture asci	Accuracy Acy tes (poor accuracy of 56%) Low gradient Tuberculosis Malignant Nephrotic synd. Pancreatic ascites Biliary ascites Chylous ascites re is low salt intake. • Excess of vitamins in form of fruits and vegetables. • Not more one liter of fluids, per day. • Body weight must be more than decrease in 1kg/4day. Inspite of good diet, salt-restriction rest bumetamide, ethacrynic acid give Ka supplement. Ioride and triamterene. They are weak diuretic and can be added to ascites slowly, Allowing at least 2 weeks to get good response. Complication Injury Infection Peritoneal Hag. Encephalopathy		
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