

TREATMENT

Cirrhosis due to Chronic Viral Hepatitis B or C

Management of complications of cirrhosis revolves around specific therapy for treatment of whatever complications occur (e.g., esophageal variceal hemorrhage, development of ascites and edema, or encephalopathy). In patients with chronic hepatitis B, numerous studies have shown beneficial effects of antiviral therapy, which is effective at viral suppression, as evidenced by reducing aminotransferase levels and HBV DNA levels and improving histology by reducing inflammation and fibrosis. Several clinical trials and case series have demonstrated that patients with decompensated liver disease can become compensated with the use of antiviral therapy directed against hepatitis B. Currently available therapy includes lamivudine, adefovir, telbivudine, entecavir, and tenofovir, with the latter two being preferred because of reduced risk of viral resistance. Interferon α can also be used for treating hepatitis B, but it should not be used in cirrhotics (see [Chap. 341](#)).

Treatment of patients with cirrhosis due to hepatitis C used to be more difficult because the side effects of pegylated interferon and ribavirin therapy were difficult to manage. Over the past several years, interferon-based regimens have been replaced by direct-acting antiviral protocols that are highly successful (>95% cure rate), well tolerated, and usually of short duration (8–12 weeks), but costly. These medications have truly revolutionized the treatment of hepatitis C (see [Chap. 341](#)).

CIRRHOSIS FROM AUTOIMMUNE HEPATITIS AND NONALCOHOLIC FATTY LIVER DISEASE

Other causes of posthepatitic cirrhosis include autoimmune hepatitis (AIH) and cirrhosis due to nonalcoholic steatohepatitis. Many patients with AIH present with cirrhosis that is already established. Typically, these patients will not benefit from immunosuppressive therapy with glucocorticoids or azathioprine because the AIH is