**DECOMPENSATED CIRRHOSIS: PROBLEM AND SOLUTION**

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**Introduction.** Decompensated liver cirrhosis is one of the most significant issues in modern medicine. High prevalence of asymptomatic forms of hepatitis B and C and late visit to a doctor lead to delays in the diagnosis of liver cirrhosis. Nevertheless, an appropriate therapy of decompensated cirrhosis and its complications is crucial and can considerably improve the patient`s quality of life.

**The purpose of the study.** To consider the management of decompensated cirrhosis and its complications on the example of a clinical case.

**Materials and methods of the study.** A male of 55 y. o. presented to the hospital with fatigue, lower limb edema, a feeling of stomach heaviness, increased abdominal size, weight loss of about 10 kg during the last 2 months, presence of hemorrhoids slightly bleeding. From the anamnesis it was known that the patient had drunk alcohol moderately for a long time. Also he suffered from hepatitis A in his childhood. On examination, breathing was weakened above the both lungs, more on the left. The liver was 6 cm below the right costal arch. Edema of shins and feet, ascites were revealed.

**Results.** Laboratory findings showed hypoproteinemia with hypoalbuminemia and decreased ß-globulin level along with increased γ-globulin levels; increased alkaline phosphatase level; hypokalemia; total bilirubin and gamma-glutamyltransferase levels were slightly higher than normal ranges. Markers of hepatitis B and C were negative. During ultrasonography, left atrium dilation, hepatosplenomegaly, portal hypertension, ascites were revealed. On chest X-ray – left hydrothorax. The conclusion of upper endoscopy – esophageal phlebectasia III-IV grade. Biopsy of the stomach: chronic atrophic hyperplastic active gastritis with expressed dysplasia and focal colonic metaplasia. *The established diagnosis:* Alcoholic liver cirrhosis, Child-Pugh class C, decompensation. *Complications:* Portal hypertension. Ascites 2-3 stage. Left-side hydrothorax. Esophageal varices. Hemorrhoids. *Concomitant diagnosis:* Chronic atrophic gastritis, acute stage. Coronary artery disease. Heart failure with preserved ejection fraction (EF 62%). NYHA II.

**The patient was treated according to the guidelines** with spironolactone, torasemide, potassium and magnesium asparaginate, nebivolol, pantoprazole. In addition, we used L-lysine aescinat as an antiedemic drug, L-arginine and ademetionine; also, we applied aminocaproic acid locally.

Against the background of the treatment, the patient condition improved: the abdominal size was reduced, shin and feet edemas vanished; the patient didn’t complain of stomach heaviness, there was no rectal bleeding.

**Conclusion.**   Liver cirrhosis is a complex disease that affects multiple body systems, therefore, requires a systematic approach to the disease management. The management of a patient with decompensated liver cirrhosis is aimed not so much at treating the complications that arise, but at preventing the progression of the disease itself.