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Budd-Chiari syndrome with short-length stenosis. Still room for the angioplasty and the "wait and see" strategy.

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We read with interest the study by Qiuhe Wang and colleagues.[1] This randomized controlled trial aimed to elucidate whether routine stenting plus angioplasty was superior to angioplasty alone for preventing restenosis in Budd-Chiari syndrome (BCS) patients with short-length stenosis. Authors found that patients treated with angioplasty plus routine stenting had a lower incidence of restenosis than patients treated with angioplasty alone without differences in survival. Based on these findings, authors suggested that stenting combined with angioplasty should be used as a first-line invasive treatment in BCS patients with short-length stenosis.

However, we have some concerns about the strength and reproducibility of their findings in different cohorts of BCS patients. The extremely long median disease time (13 and 20 years in the angioplasty-only and the stenting plus angioplasty groups respectively) before randomization, which differs from previous data,[2] strongly suggests a huge selection bias including mostly surviving patients with, according to table 1 of the manuscript, few symptoms (or even asymptomatic). In this regard, a hallmark study from the Clichy group clearly showed that there is a group of asymptomatic BCS patients, who usually present large intrahepatic venous collaterals that decompress, at least partially, the portal venous system.[3] Usually, this group of patients has an excellent prognosis and does not require more invasive treatment if further thrombosis is prevented by anticoagulation.[3] Contrarily, it is difficult to understand why patients with severe complications of portal hypertension, such as refractory ascites or recurrent variceal bleeding, were excluded. Indeed, these patients may also benefit from restoring the physiological hepatic blood outflow, by solving the short-hepatic vein stenosis, and avoiding the need of a TIPS.[4] It is important to remark that 60% of patients treated with angioplasty alone did not develop restenosis and had an excellent survival. Whether similar results would have been found if more severe patients would have been included in this study is an unanswered question. Unfortunately, the authors did not explore risk factors for restenosis in the angioplasty-only group as an attempt to identify the 40% of patients who may benefit from early stenting. As already mentioned by the authors and the accompanying editorial,[1,5] more data about the potential impact of stenting in BCS patients requiring further treatments is needed.

Certainly, further studies are needed to answer these questions. Until then, we believe that the "wait and see" strategy following angioplasty still has a role in the management of BCS patients with short-length stenosis.

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