

Variceal Bleeding Management: EASL 2026 Skills Centre Focuses on Endoscopic and Pharmacological Strategies

Written by The Life Science Feed Editorial Team · Published 19 May 2026 · Edited by Mara Voss

Variceal bleeding remains a critical complication of portal hypertension, associated with significant morbidity and mortality.¹ The EASL 2026 Skills Learning Centre on variceal bleeding will provide an essential update on established and emerging management strategies, focusing on the immediate clinical decisions required for effective patient care.

KEY TAKEAWAYS

- **The Pivot:** The Skills Centre reinforces the primary role of endoscopic therapy combined with pharmacological agents in acute variceal bleeding and secondary prophylaxis.
- **The Data:** Early pre-emptive transjugular intrahepatic portosystemic shunt (TIPS) in high-risk patients reduces rebleeding and improves survival compared to standard therapy.
- **The Action:** Clinicians should ensure timely endoscopic intervention and appropriate pharmacological support, considering early TIPS for selected high-risk patients.

Acute variceal bleeding represents a medical emergency, with initial mortality rates historically approaching 20%.¹ The primary goal of management is to achieve haemostasis, prevent early rebleeding, and improve survival. The EASL 2026 Skills Learning Centre will review the evidence base for current guidelines, emphasising the practical application of therapeutic strategies.

Variceal bleeding is a severe complication of portal hypertension, most commonly seen in patients with cirrhosis. The elevated pressure in the portal venous system leads to the formation and enlargement of collateral vessels, known as varices, predominantly in the oesophagus and stomach. These varices are prone to rupture, causing life-threatening haemorrhage. The incidence of variceal bleeding in cirrhotic patients is approximately 5-15% per year, with a cumulative risk of up to 30% over two years in patients with large varices. Early and effective intervention is critical to mitigate the high morbidity and mortality associated with this condition.

Initial management involves resuscitation, pharmacological vasoconstrictors, and endoscopic therapy. Vasoactive drugs, such as terlipressin or octreotide, are initiated immediately upon suspicion of variceal bleeding to reduce portal pressure. Terlipressin, administered intravenously, has been shown to improve survival at 48 hours compared to placebo (odds ratio, 0.66; 95% CI, 0.49-0.88).² Octreotide, a somatostatin analogue, also reduces splanchnic blood flow and portal pressure, with comparable efficacy to terlipressin in some settings.³ These pharmacological agents work by inducing splanchnic

vasoconstriction, thereby reducing blood flow into the portal system and subsequently lowering portal pressure. This initial reduction in portal pressure helps to control bleeding while definitive endoscopic therapy is prepared.

Endoscopic and Pharmacological Interventions

Endoscopic therapy, primarily variceal band ligation (EVL) for oesophageal varices or cyanoacrylate injection for gastric varices, is performed within 12 hours of presentation. EVL is superior to sclerotherapy for oesophageal varices, demonstrating lower rebleeding rates and fewer complications.⁴ For gastric varices, particularly fundal varices, cyanoacrylate injection achieves haemostasis in 90-100% of cases.⁵ The choice of endoscopic technique depends on the location and morphology of the varices. EVL involves placing elastic bands around the varices, leading to their strangulation and eventual obliteration. Cyanoacrylate injection involves injecting a tissue adhesive directly into the varices, causing immediate thrombosis and occlusion. These procedures require skilled endoscopists and appropriate equipment, which the EASL Skills Centre aims to reinforce through practical training modules.

Following successful haemostasis, secondary prophylaxis is crucial to prevent rebleeding. This typically involves a combination of non-selective beta-blockers (NSBBs) and repeated EVL. NSBBs, such as propranolol or carvedilol, reduce portal pressure and have demonstrated a significant reduction in rebleeding rates. Carvedilol, specifically, has shown superior portal pressure reduction compared to propranolol.⁶ The combination of NSBBs and EVL is more effective than either therapy alone for secondary prophylaxis.⁷ NSBBs reduce portal pressure by decreasing cardiac output and inducing splanchnic vasoconstriction. The combined approach targets both the underlying portal hypertension and the local variceal pathology, providing comprehensive protection against recurrent bleeding episodes. Patient adherence to long-term NSBB therapy is a critical factor in the success of secondary prophylaxis.

For patients at high risk of rebleeding, or those who fail endoscopic and pharmacological therapy, transjugular intrahepatic portosystemic shunt (TIPS) is an established intervention. Early pre-emptive TIPS, performed within 72 hours of acute variceal bleeding in selected high-risk patients (Child-Pugh class B with active bleeding or Child-Pugh class C 0.56; 95% CI, 0.38-0.82).⁸ TIPS involves creating a shunt within the liver to decompress the portal venous system, directly reducing portal pressure. This procedure is particularly beneficial for patients with severe liver dysfunction or those who experience recurrent bleeding despite optimal medical and endoscopic management. Careful patient selection is paramount to balance the benefits of portal decompression against the potential risks of hepatic encephalopathy and other shunt-related complications.

The Skills Centre will also address the management of refractory bleeding and complications such as post-bleeding infection. Prophylactic antibiotics are recommended for all patients with cirrhosis and acute variceal bleeding, significantly reducing bacterial infections and improving survival. A 7-day course of intravenous ceftriaxone is commonly used.⁹ Patients with cirrhosis are immunocompromised, making them highly susceptible to bacterial infections, which can precipitate further bleeding episodes and worsen prognosis. The prompt administration of antibiotics is a cornerstone of comprehensive management. The Centre will also cover strategies for managing acute kidney injury, which is a frequent complication in this patient population, often exacerbated by hypovolemia and vasoactive drug use.

Limitations in current practice include the timely identification of high-risk patients for early TIPS and ensuring consistent application of guideline-recommended therapies across diverse clinical settings. Variability in resource availability, particularly in endoscopy services and interventional radiology for TIPS, can impact patient outcomes.

Furthermore, accurate risk stratification tools, such as the Child-Pugh score and MELD score, are essential but require careful interpretation in the acute setting. Future directions may involve further refinement of risk stratification tools and exploring novel pharmacological agents that target portal hypertension more effectively. Research into new endoscopic techniques and devices, as well as personalized medicine approaches based on individual patient characteristics and genetic profiles, may also enhance future management strategies for variceal bleeding.

For a comprehensive understanding of the underlying liver conditions contributing to variceal bleeding, readers may find further insights in Sherlock's Diseases of the Liver and Biliary System.

CLINICAL IMPLICATIONS

The continued focus on variceal bleeding at EASL 2026 underscores the persistent challenge this condition poses in hepatology. While the evidence base for endoscopic and pharmacological interventions is robust, the practical application, particularly the timely identification and referral for early TIPS in high-risk patients, remains a critical area for improvement. Clinicians must move beyond a reactive approach to acute bleeding and proactively consider the full spectrum of prophylactic strategies, including NSBBs and serial EVL, to truly impact patient outcomes.

The industry's role in supporting these efforts is multifaceted. Pharmaceutical companies developing new vasoactive agents or improved formulations of existing drugs could offer incremental benefits, though significant breakthroughs in portal pressure reduction remain elusive. Device manufacturers, particularly those involved in endoscopic equipment and TIPS prostheses, have a clear incentive to innovate for enhanced safety and efficacy. However, the primary impact will come from better education and implementation of existing, proven therapies rather than relying solely on novel, unproven technologies.

For patients, the implications are clear: consistent adherence to established guidelines by healthcare providers directly translates to reduced rebleeding episodes, fewer complications, and improved survival. The emphasis on skills training at EASL suggests that despite clear guidelines from bodies like AASLD and EASL, there is still a gap in practical competence or consistent application. This gap must be closed to ensure that every patient presenting with variceal bleeding receives optimal, evidence-based care, regardless of the clinical setting.

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