INTRODUCTION

A major complication of portal hypertension in patients with cirrhosis is the development of esophageal varices with the associated risk of variceal bleeding. Hence, the Baveno consensus on portal hypertension in its first five editions had recommended surveillance with periodic upper endoscopies in these patients to identify in a timely fashion the development of esophageal varices and initiate a primary prophylactic strategy in those at a high risk of bleeding. For the first time, the Sixth Baveno Consensus on Portal Hypertension (Baveno VI) recommended using non-invasive tools to rule out the presence of varices with a high risk of bleeding. According to Baveno VI, surveillance endoscopy is not necessary for patients with “compensated advanced chronic liver disease” (cACLD) who have normal platelets (>150×10^9/L) and a liver stiffness measure (LSM) <20 kPa. In this review, we will briefly describe the currently available non-invasive methods to predict the presence of varices, such as serum tests, imaging, and elastography. We will also discuss the rationale that led to Baveno VI recommendation and describe the studies that have validated Baveno VI criteria after its publication. Finally, we will mention some potential caveats and suggest some areas for future research.

Stages of Chronic Liver Disease

The progression of chronic liver disease has been divided into stages, each of them with a different prognosis (3,4). The spectrum of chronic liver disease includes the onset of cACLD, the development of clinically significant portal hypertension (CSPH), the formation of varices, decompensation, and a “further decompensation” stage (Figure 1) (5). The term cACLD is new and it encompasses patients with early compensated cirrhosis as well as patients with severe fibrosis, as it is difficult to...
to distinguish between them (2). Baveno VI recommended a cutoff point of liver stiffness of <10 and >15 kPa to rule-out and rule-in cACLD, respectively (1).

Patients with compensated and decompensated cirrhosis have a mean survival of 12 and 2 years, respectively (3). The development of CSPH, defined as a hepatic venous pressure gradient (HVPG) ≥10 mmHg in patients with compensated cirrhosis, is an event that markedly worsens prognosis, as patients without CSPH do not develop esophageal varices or complications related to portal hypertension (6). Furthermore, it is above this threshold that patients with cirrhosis develop a hyperdynamic circulation. Therefore, CSPH is considered as the most important predictor of decompensation. The 5-year risk of decompensation in patients with and without CSPH is 40% and 10%, respectively (2,7). In addition to this, mortality in patients with CSPH who have developed varices is higher than in patients without varices (Figure 1) (8).

Patients with compensated cirrhosis develop varices at a rate of 7%-8% per year (9). In the case of patients with small varices (<5 mm), they progress to large varices at a rate of 10%-12% per year (10). Primary prophylaxis refers to strategies applied to prevent the first episode of variceal bleeding. Randomized controlled trials have shown that either non-selective beta-blockers or endoscopic variceal ligation is effective to reduce the risk of bleeding in patients with high-risk varices, either large varices or small varices with red signs (1). These varices are globally called varices needing treatment (VNT). There is no evidence to support a beneficial effect of beta-blockers in patients with no varices (11). When it comes to small varices without red signs, even though it may seem reasonable to start a pharmacological treatment to prevent variceal growth, yet there is no sufficient evidence to recommend this strategy. A meta-analysis of six studies failed to show any benefit of prescribing beta-blockers to patients with no or small varices. A subanalysis of the three studies which evaluated the progression from small to large varices was also negative. However, there was significant heterogeneity among the studies. Importantly, patients treated with beta-blockers had more adverse events than patients taking placebo (12,13). A more recent randomized controlled trial, not included in the above-mentioned meta-analysis, showed that carvedilol was effective in delaying the progression of small to large esophageal varices (14). However, further confirmatory evidence would be needed before this can be recommended. At present, therefore, initiation of primary prophylaxis for variceal bleeding requires identifying the presence of VNT. To this end, the Baveno consensus has traditionally recommended surveillance with periodic upper endoscopies in patients with liver cirrhosis. However, Baveno VI, for the first time, recommended the use of non-invasive methods to triage patients who would benefit from surveillance endoscopy. Specifically, patients with an LSM <20 kPa and normal platelets (>150x10⁹) are considered to have a probability of having VNT of <5% and do not need to undergo endoscopy. Of note, the patient has to be reassessed on a yearly basis (1).

**Non-Invasive Methods for the Detection of VNT**

There has been extensive research regarding the use of non-invasive methods to diagnose CSPH, the development of varices, and VNT. In this review, we will only address studies focused on identifying VNT because this is what triggers a therapeutic intervention, either initiating a beta-blocker or endoscopic variceal ligation (1). Non-invasive methods can roughly be categorized into four groups: serum tests, imaging, elastography, and the combination of these methods.
Liver stiffness measure with elastographic methods has re-
tained to radiation (18). Moreover, MRI is not easily accessible, and CT exposes the pa-
patients. Some of the most common param-
eters were studied extensively in a retrospective set of 510 and a
prospective set of 110 patients with cirrhosis. The results of this
study, as well as the accuracy of FibroTest® (BioPredictive, Paris,
France) for detection of VNT, are shown in Table 1 (15,16).

Serological methods offer the advantage of accessibility and a
reasonable cost, as they usually use simple parameters such as
platelets, aspartate aminotransferase, alkaline aminotransferase,
and demographic variables. Some of the most common param-
eters are AST to platelet ratio index (APRI), the platelet-to-spleen
ratio (PSR), Forns index, and FibroTest® (FibroScan®, Echosens, Paris,
France) for detection of VNT, as shown in Table 1 (15,16).

In the case of imaging methods, some parameters measured
by Doppler ultrasound have shown reasonable predictive val-
ues (17). However, the limitations of this method include that it
is highly observer-dependent. Cross-sectional studies such as
computed tomography (CT) and magnetic resonance imaging
(MRI) are considered to be specific, but not sensitive enough.
Moreover, MRI is not easily accessible, and CT exposes the pa-
tient to radiation (18).

Liver stiffness measure with elastographic methods has re-
ceived massive attention in the last decade. The most com-
monly used method has been vibration-controlled transient
elastography (TE) (FibroScan®, Echosens, Paris, France). LSM-TE
has been extensively studied in the prediction of large varices
with some variability in the results but in most studies showing
a negative predictive value (NPV) above 90% (19-21). Never-
theless, studies were highly heterogeneous and this made it
difficult to establish a defined threshold value that could be
used to triage patients not needing endoscopy. In the case of
spleen stiffness measurement (SSM), a meta-analysis showed a
suboptimal performance for the detection of VNT, with sensi-

Table 1. Performance of non-invasive serological methods for prediction
of high-risk varices*

<table>
<thead>
<tr>
<th>Index</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>PPV</th>
<th>NPV</th>
<th>AUC</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRI</td>
<td>57</td>
<td>56</td>
<td>35</td>
<td>76</td>
<td>0.57</td>
</tr>
<tr>
<td>FIB-4</td>
<td>71</td>
<td>56</td>
<td>40</td>
<td>82</td>
<td>0.63</td>
</tr>
<tr>
<td>Forns</td>
<td>70</td>
<td>62</td>
<td>58</td>
<td>82</td>
<td>0.66</td>
</tr>
<tr>
<td>Lok Score</td>
<td>71</td>
<td>68</td>
<td>50</td>
<td>84</td>
<td>0.70</td>
</tr>
<tr>
<td>Forns Index+Lok Score</td>
<td>84</td>
<td>73</td>
<td>58</td>
<td>91</td>
<td>0.80</td>
</tr>
<tr>
<td>Platelets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;150,000</td>
<td>54</td>
<td>75</td>
<td>49</td>
<td>80</td>
<td>0.65</td>
</tr>
<tr>
<td>Fibro Test***</td>
<td>92</td>
<td>21</td>
<td>33</td>
<td>86</td>
<td>0.77</td>
</tr>
</tbody>
</table>

Modified from reference 15.
*Includes small varices with high-risk stigmata and large varices.
**Only assessed prediction of large esophageal varices.
***Includes small varices with high-risk stigmata.
AUC: area under the curve; APRI: AST to platelet ratio index; PPV: positive predictive value;
NPV: negative predictive value

When trying to combine LSM-TE with serological tests, the best
accuracy was obtained when adding the Lok Score, with an
NPV of 94% for large varices (27). The combination of LSM-TE
and SSM shows the same NPV of 94% for large varices (22). As
expected, an algorithm that takes into account these three
results (LSM-TE, SSM, and the Lok Score) increased its perfor-

The LSM-spleen diameter to platelet ratio score (LSPS) has
shown an NPV of 93.3% for VNT in patients with HBV cirrho-

The platelet-to-spleen ratio (PSR) is an easy-to-calculate index,
described by Giannini and colleagues that initially showed an
excellent performance for predicting varices (31). However, in
validation studies, it did not perform as well when compared
with other methods (30,32). A meta-analysis of 20 studies calcu-

Despite this large corpus of data on the value of non-invasive
tools to predict the presence of varices, rather surprisingly,
these did not permeate clinical practice until very recently. A
significant barrier for this lack of knowledge translation has
been, in our view, the use of diagnostic performance measure-
ments without direct clinical interpretation, such as sensitiv-

More recently, a multicenter Canadian-European study (the
ANTICIPATE study) (30) addressed these issues by providing a
different approach to report the performance of non-invasive
tests. The bottom line of that study was to use risk prediction
Rationale for the Baveno VI Criteria

An endoscopy is an invasive procedure that has the potential for complications and in some cases may be an unnecessary burden for some patients. Besides, with the increasing use of non-invasive methods, the population of patients with cACLD is growing, subsequently increasing the overload of endoscopy units (37,38). Although the ideal non-invasive tool would be able to select patients with a 0% risk of VNT, and therefore no patient with VNT would be missed, this is an unrealistic scenario. Taking this into account, during the Baveno Consensus Conference, it was agreed that a prediction rule that would be able to select patients with a risk of VNT lower than 5% and at the same time would save a relevant number of endoscopies could be a reasonable trade-off (1). It is important to emphasize that this criterion is different from a test with an NPV of 95% (Figure 2). In the case of a 95% NPV, the test would identify a group of patients with an overall risk of having varices of 5%.

This 5% figure would be the mean of the pooled risks of the patients included in this group, that is, in this group, a relevant number of patients could have risk of varices over 5%, and this would not be in keeping with the “less than 5% risk” concept. This is different from a decision threshold of ≥5% risk to perform an endoscopy.

A second agreement was that the combined use of more than one non-invasive method would be better than any method alone (39,40). Finally, looking for simplicity and clinical practice applicability, Baveno VI considered that a simple rule using platelets and LSM-TE would be more useful than other combinations, as methods incorporating spleen diameter/volume had the inconvenience that these ultrasound measurements are highly observer-dependent and therefore subject to variability. In addition, it was taken into account that, although very promising, methods measuring SSM were still undeveloped and had a high failure rate. The Baveno VI consensus, thus, proposed that patients with compensated cirrhosis do not need surveillance endoscopy if platelets are in the normal range (>150x10^9/L) and LSM-TE is <20 kPa, as this combination identifies the 5% risk threshold of having VNT (1).

Prospective Validation of Baveno VI Recommendation

After the Baveno VI Conference, there have been a number of studies validating the recommendation of circumventing upper endoscopy in those patients with cACLD with normal platelets and LSM-TE <20 kPa. These studies have targeted different cACLD populations as can be seen by the variable prevalence of varices among them, which could be as low as 23% and as high as 65%. Of note, studies with a prevalence of varices more than 40% probably included patients with advanced cirrhosis, in whom using non-invasive tests to triage patients for endoscopy is not recommended. The main etiologies of cACLD were viral and alcohol-related. Overall, the percentage of missed VNT has been 2% or less in all of them, in keeping with the proposed <5% threshold defined by Baveno VI. In these studies, around 20% of endoscopies could have been saved by applying the criteria (41).

Maurice et al. (42) showed in 310 patients with cirrhosis an NPV of the Baveno criteria of 98%. Of note, 11% of the patients had decompensated cirrhosis. In a subsequent study, Perezolo et al. (43) included 99 patients with HCV cACLD. NPV was 100% and adding SSM to the model did not provide additional benefit. Tosetti et al. (44) showed a 100% sensitivity and NPV of Baveno criteria in 165 patients with virus-related cACLD. When the authors modified the cut-off points of LSM to <25 kPa and platelets to >125x10^9/L, LSM-TE was still 100%, which would suggest that maybe less conservative cut-off points could be used. However, data-driven modification of a set of criteria generally leads to over-optimistic performance estimates. Turco et al. (45) also validated Baveno VI criteria in two different cohorts, one in the United States consisting of 205 patients and another in Italy consisting of 111 patients, achieving an NPV of 100%.
Again, a data-driven modification of the thresholds to <21 kPa and >110x10^9/L platelets did not decrease the performance of the criteria. They additionally proposed that in those patients with results above these cut-off points, an MELD (model for end-stage liver disease) score lower than 7 could be used to rule out the presence of VNT. The use of these expanded criteria would have resulted in an increase from 22% to 50% in the number of saved endoscopies. In the study by Ding et al. (38), an NPV of 100% was achieved in both the training (n=71) and validation (n=200) cohorts using cut-off points of ≤25 kPa and ≥100x10^9/L for platelets.

A recent random-effects model meta-analysis that included 15 studies that used platelet count and LSM to identify patients with esophageal varices found that the percentage of missed VNT was no more than 4%. A 4.5-fold risk reduction of VNT in patients with normal platelets and low stiffness was calculated, with a sensitivity of 93%, specificity of 30%, NPV of 97%, and positive predictive value (PPV) of 14%. When including only studies using the thresholds proposed by Baveno VI, the percentage of missed VNT was 3.1%. Of note, there was no significant heterogeneity among the studies. However, the definition of VNT was different among the studies and although most were conducted in compensated patients, four of them also included decompensated patients in the analysis (46).

**Limitations of the Baveno Criteria**

When compared with the gold standard for diagnosing VNT (i.e., endoscopy), the recommendation made by Baveno VI is not 100% accurate and has some limitations, discussed below.

First, LSM-TE may show day-to-day variations (47) and might additionally vary with the position of the probe (48), body mass index, and the operator (39). In addition to this, LSM-TE may not be technically feasible in up to 20% of patients because of obesity, which is a problem due to the fact that NAFLD (non-alcoholic fatty liver disease) is becoming the most common liver disease. This problem has been partially addressed by using the XL probe, which can increase success rate to almost 85% (49). Nevertheless, this probe may give lower stiffness measures and studies that have validated LSM-TE for the prediction of high-risk varices have used the M probe, questioning whether the same thresholds can be applied with both probes.

Second, in order for LSM-TE to be reliable, it should be done by an experienced operator, defined as someone who has performed more than 100 examinations (50). Moreover, access to TE is limited in under-developed countries, where applicability of less accurate but more accessible models will need to be intentionally validated.

Third, as stated by European Association for the Study of Liver guidelines, TE should always be interpreted according to the clinical context and considering the results of other tests. It is important to identify *a priori* any comorbidity or condition that may affect the results of liver stiffness and/or platelet count, as that would make its results unreliable. Congestive heart failure, transaminases flares, post-prandial status, extrahepatic cholestasis, and excessive alcohol intake can falsely elevate the measurement of LSM (50). On the other hand, several factors might have a significant impact in platelet count. HCV/HBV and HIV infections may lead to thrombocytopenia by immune-mediated mechanisms, independent of portal hypertension, whereas a past splenectomy might falsely normalize the platelet count in the presence of severe portal hypertension (51,52). Indeed, in the study done by Maurice and colleagues, one of the two cases, where VNT was missed by the Baveno VI criteria, had a previous splenectomy (42).

Finally, it is important to emphasize that the recommendations have been designed to be applied in patients with cACLD and not in patients with decompensated cirrhosis. The post-test probability of VNT <5% with the Baveno VI criteria may not apply to patients with decompensated cirrhosis, where the pre-test probability of VNT is much higher.

**Future Areas of Research**

In patients at low risk of VNT, the Baveno VI consensus suggests yearly re-assessment of the non-invasive tests to assess for potential disease progression. Only long-term follow-up studies will be able to determine whether this strategy is able to identify the development of VNT in a patient who was previously considered at low risk. Along these lines, a recent study (53) evaluating 156 patients without VNT who had LSM and platelets within Baveno VI criteria showed that the decrease in platelets and/or the increase in LSM during follow-up was associated with progression of portal hypertension, defined as the appearance and/or growth of varices. On the other hand, with emerging therapies able to improve fibrosis and subsequently LSM, such as direct antiviral agents in the case of HBV/HCV or obeticholic acid in NAFLD, it will be necessary to assess whether screening endoscopies can be avoided when the patient reaches an LSM of <20 kPa, as the post-treatment relationship between elastography and fibrosis, portal hypertension, and/or varices might not be the same as in untreated patients (54-56).

The role of etiology is another major source of controversy. The predominant etiology in most of the studies that have validated the Baveno VI recommendation has been viral hepatitis, alcohol being the second in frequency. Initial results show that the same thresholds can be used independently of the etiology of the liver disease (30,42), but studies specifically designed to validate Baveno prediction rule in other etiologies are needed. Finally, maybe less stringent criteria can be applied using a lower cut-off of platelets and/or a higher cut-off point for LSM, to spare more endoscopies, but that would again require further modeling and validation studies. The ultimate validation of this strategy would require a randomized controlled trial, comparing the incidence of the relevant outcome (variceal bleeding).
between a group using this strategy to triage patients for endoscopy and a group subject to universal endoscopy policy, including a cost and quality-of-life analysis (30).

In conclusion, Baveno VI recommendations to triage patients with compensated cirrhosis in need of screening endoscopy have proven robust in the real-world setting. Further studies are needed to address specific concerns such as its validity in non-viral etiologies of cACLD, in studies done with the XL probe, and whether different thresholds may be used to increase the number of surveillance endoscopies that can be spared. In addition to this, validation of models that do not incorporate LSM-TE is still needed for expanding their use in places where elastography is not accessible.

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