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Posters



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Frequency of Her2/*neu* expression in colorectal adenocarcinoma: A study from developing South Asian country

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Background & Purpose: Human Epidermal Growth Factor (Her-2/*neu*) has strong therapeutic implications in certain cancers like breast and gastric cancer. Literature on its frequency in colorectal cancer is scarce. In this study, we have investigated the frequency of Her-2/*neu* expression in colorectal adenocarcinomas and its association with various clinicopathological variables.

Methods: A total of 95 patients who underwent colonoscopic biopsy or colectomy were studied after institutional ethical approval. Hematoxylin & eosin (H&E) staining was performed on all the tissue sections. Expression of Her-2/*neu* was investigated by immunohistochemistry using α -Her-2 antibody. In order to quantify Her-2/*neu* expression, three criteria were applied that includes the pattern of staining, intensity of staining and percentage of tumor cells stained. Furthermore, its association was seen with various clinicopathological variables including age, gender, histopathological type, grade and stage of the tumor. Data was entered and analyzed using SPSS version 21. A p-value of <0.05 was considered as significant.

Results: From the total of 95 cases, 75 (78.9%) cases showed Her-2/*neu* expression. Pattern of Her-2/*neu* staining was significantly associated with the grade (p-value=0.030) and type of colorectal cancer (p-value=0.024). We also observed a significant association between percentage of cells stained and tumor type (p-value=0.006).

Conclusion: Her2/*neu* is considerably expressed in colorectal adenocarcinoma in Pakistani population. Our findings indicate a significant strong association of cytoplasmic Her-2/*neu* expression with low grades and membranous Her-2/*neu* expression with high grades of colorectal cancer.

Biography

Asma Shabbir has a passion towards research and is concerned for better prognosis of the illnesses (especially cancer patients). Her primary area of expertise is diagnostic pathology and also adores to teach the medical students. Her dissertation work involved evaluation of Her-2/*neu* in gastric and colorectal adenocarcinomas, the basis of which arised from the use of targeted therapy (α -Her-2) in breast cancer patients. Similarly, α -Her-2 therapy in gastric and colorectal cancer might give another treatment option for better prognosis to these patients in this new era of personalized medicine.

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Notes:

Value of CT enterography in predicting activity of Crohn's disease: Correlation between Crohn's disease activity index and CRP

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Background: The accurate evaluation of disease activity in Crohn's disease is important in treatment of the disease and monitoring the response. CT enterography is a useful imaging modality reflecting the enteric inflammation as well as extramural complications.

Objectives: To evaluate the correlation of CT enterographic findings of active Crohn's disease with the Crohn's Disease Activity Index (CDAI) and CRP.

Patients & Methods: 50 CT enterographies in 39 patients with Crohn's disease in the small bowel were enrolled in our study. CDAI was assessed through clinical or laboratory variables. Multiple CT parameters including mural hyper-enhancement, mural thickness, mural stratification, comb sign and mesenteric fat attenuation were examined with four-point scale. The presence of enhanced lymph nodes, fibro-fatty proliferation, sinus or fistula, abscess and stricture were also assessed. Two gastrointestinal radiologists independently reviewed all CT images. The inter-observer agreement was also examined. Correlations between CT findings, CRP and CDAI were assessed using Spearman's rank correlation and logistic regression analysis. To assess the predictive accuracy of the model, receiver-operating characteristic curve analysis for sum of CT enterographic scores was used.

Results: Mural hyper-enhancement, mural thickness, comb sign, mesenteric fat density, fibro-fatty proliferation, fistula and abscess were significantly correlated with CDAI ($p < 0.05$). Mesenteric fat density was correlated with CRP ($r = 0.32$; $p = 0.02$). The binary logistic regression model demonstrated that mesenteric fat density ($p = 0.02$) had an influence on the severity of CDAI. The AUROC of CTE index for predicting disease activity was 0.85. Using cut-off value of 8, the sensitivity and negative predictive value were 95% and 94%.

Conclusions: Most CTE findings are correlated with CDAI and CRP in patients with active Crohn's disease.

Biography

Min Ju Kim is an Abdominal Radiologist with an expertise in evaluation of gastrointestinal disease. She has reviewed about rectal ultrasonography and inflammatory bowel disease and there are many articles about gastrointestinal diseases, especially in inflammatory bowel disease or rectal MRI for evaluation of rectal cancer. She is at present a Professor of Korea University Medical School in Seoul, Korea and is teaching gastrointestinal radiology.

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Laparoscopic cholecystectomy for acute cholecystitis with previous abdominal surgery

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Introduction & Aim: The aim of this study was to find out if laparoscopic cholecystectomy for acute cholecystitis is also an adequate surgical procedure in patients with a status post previous abdominal surgeries.

Material & Methods: Between 1.4.2010 till 31.8.2013, 858 patients underwent surgery for chronic cholecystitis (n=595) or acute cholecystitis (n=245). 788 of the patients had their surgeries done minimal invasively. 56 of the patients had a history of a previous abdominal surgery. 32% of all previous surgeries were upper abdominal and 68% lower abdominal. All patients with a history of lower abdominal laparotomy had their camera trocar supraumbilically introduced, whereas in patients with previous upper abdominal surgeries the location of the camera trocar was variable and a function of the previous abdominal incision. The introduction of the other trocar ports was after careful adhesiolysis under optical vision in the usual abdominal wall locations.

Results: A laparoscopic cholecystectomy was possible in all 245 acute cholecystitis patients. The conversion rate in acute cholecystitis after previous abdominal surgery (n= 18) was 5.5% and the median duration of surgery was 95 minutes (69 to 235 minutes). The median hospital stay was 8 days (4 to 18 days) which was not much longer than in laparoscopic cholecystectomy in patients no previous abdominal surgeries.

Conclusion: Laparoscopic cholecystectomy for acute cholecystitis is also an adequate procedure in patients with a history of previous abdominal surgeries associated with low rate of complication.

Biography

Amal A Hunjur has obtained her MBBS in May 2016. She has a passion in improving patients' quality of life and health awareness. She attended the "Medical Emergencies: Updates and Practice Management Symposium 2015" and research methodology course in 2015. She participated in the Taif's 1st Trauma course, Breast Cancer Awareness Campaign in 2011, AIDS Awareness Campaign in 2012, ADHD awareness Campaign in 2015 and Breast Cancer Awareness Campaign in 2016. She presented in the 7th Saudi Students' Scientific Conference 2016. She believes that clinical researches are the basic key and the cornerstone for clinical development. She has published in the *World Journal of Neuroscience* under the title of "Siblings with Autism, Mental Retardation & Convulsion in Tuberous Sclerosis". She is currently working on improving her research experience, clinical practice and medical knowledge, aiming for giving the best to her mission as a physician.

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Necrotizing Soft Tissue Infections: Clinical Profile, effect of associated co-morbidities, traumatic injuries and duration of symptoms before admission on hospital stay

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Introduction: Necrotizing soft tissue infections is used to encompass infections not only of fascia, as in necrotizing fasciitis, but also of other soft tissue affected. Necrotizing fasciitis is a progressive, fulminant bacterial infection of subcutaneous tissue that spreads rapidly through the facial planes causing extensive tissue destruction. NSTIs are rare but potentially fatal condition. In the United States, there is an estimated annual incidence of 0.04 cases per 1000 annually. Early reports of mortality were variable with rates ranging from 46 to 76% but outcomes have been improving over time. The mainstay of treatment is early and complete surgical debridement, combined with antimicrobial therapy, close monitoring, and physiologic support. Total debridement of all necrotic material must be performed until the skin and subcutaneous tissue can no longer be separated from deep fascia. Novel therapeutic strategies, including hyperbaric oxygen and intravenous immunoglobulin, have been described, but their effect is controversial. Identification of patients at high risk of mortality is essential for selection of patients that may benefit from future novel treatments and for development and comparison of future trials.

Study: Retrospective**Aim:** To analyze clinical profile, effect of associated co-morbidities, trauma and duration of symptoms before admission on hospital stay**Study group:** 25cases of NSTIs who reported to our hospital during January to December 2015(formula used- $ME=z*\sqrt{\frac{p(1-p)}{N}}$)**Exclusions:** deaths (two)**Co-morbidities included:** Diabetes mellitus, Chronic liver disease, Respiratory disease, Respiratory disease, Vascular disease, Dyselectrolytemia

(No patient was found to have any renal disease)

Results: study showed that the disease is more common in males (80%) and in patients with age group 51-60 years (48%), more in patients with diabetes mellitus (60%),traumatic injuries(32%) and in patients with other co-morbidities(40%). 40% patients had a history of 10-15 days of illness before presenting to hospital.44% patients had less than 4 days of hospital stay. There is no correlation between duration of symptoms before admission or hospital stay in patients with associated co-morbidities and trauma. There is no correlation between duration of symptoms before admission and hospital stay. There is increased hospital stay in patients with associated co-morbidities especially in liver pathology or electrolyte imbalance compared to other comorbidities

Biography

Hemant Atri has completed his MBBS from P.D.U. Medical College, Rajkot, Gujarat and currently pursuing Post-graduation in DNB Surgery at Fortis Escorts Hospital, Faridabad, India.

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Neuroendocrine tumors of the rectum

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Aim: To investigate the disease profile of neuroendocrine tumours (NET) of the rectum

Methods: Retrospective review of all the cases managed at a tertiary unit.

Results: A total of 57 cases were identified (median age 53 years: IQR 42-67; 61% were males). The median tumor size was 5mm. Female patient had larger sized tumor compared to males (p 0.01). About 54% of patients presented with rectal bleeding. NETS 1 cm accounted to 80.6% of the tumors. The frequency of grades low (G1), intermediate (G2) and high (G3) were 63%, 18.5% and 18.5%, respectively. The Ki-67 staining of $\leq 2\%$ was 53%, $>2-20\%$ was 41.5% and $>20\%$ was G3 6%. Tumor $> 5\text{mm}$ frequently showed G2 and G3 Ki67 (Kendall B, p 0.03) staining. Frequently positive markers also included synaptophysin in 49/50 (86%), CD56 30/32 (52.6%) and chromogranin 25/50 (50%) cases, respectively. Distant metastasis was present in 21% at the time of diagnosis (commonly in G3 NETS; 60%) and developed in 8.8% after curative treatment. Major surgical resection was only indicated in 9 (15.7%) patients. The median survival was 32 months (95%CI 19.7 – 44.2 months). About 7 patients (12.3%) died because of the disease process, however, the 5-year DFS and OS were 66% and 21%, respectively.

Conclusions: Rectal NETS are commonly symptomatic with 80% 1 cm in size requiring minimal surgical treatment to achieve cure. Five-year DFS and OS were independent of tumour size and grading.

Table 1: Clinical features

Age	55 years (IQR 43 – 67 years)	
Gender	Male= 35 (61%); Female = 22 (38%)	
Presenting Symptoms	Rectal bleeding	29 (55%)
	Incidental	9 (17%)
	Bowel habit change	7 (13%)
	Abdominal pain	7 (13%)
	Bowel obstruction	1 (2%)
Colonoscopy	Polyps	48
	Tumor	10
Organs affected	Pre-Treatment Mets	7 (12.3%)
	Liver	6
	Lung	4
	Peritoneum	3

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Histopathological examination of quality of total mesorectal excision (TME): Single institution results

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Total mesorectal excision (TME) has become the contemporary standard of treatment for patients with rectal cancer. The multidisciplinary approach to colorectal cancer ensures appropriate treatment for each patient with rectal cancer. Pathologists play an important role in the evaluation of these specimens, including the quality assurance of surgical performance and evaluation of the circumferential radial margin (CRM). The most significant predictor of local recurrence and quality of the excised mesorectum is another important factor in assessing the risk of local recurrence in patients with a negative CRM. Proper pathological assessment of the TME specimen provides important prognostic information, as well as critical feedback to surgeons regarding technical performance. So, high quality histopathological reporting is necessary in the management of rectal cancer. In 2014, we began to perform pathological reports of rectal cancer according to guidelines of Royal College of Pathologists. Our reports conclude points such as site of the tumor, diameter of the tumor, distance of tumor to resection margin, histological type, degree of differentiation, TNM staging, total number of lymph nodes, isolated apical lymph node metastasis, presence/absence of lymph node metastasis, depth of invasion, neural invasion within tumor, vascular or lymphatic invasion within tumor, resection margin, presence/absence of perforation, involvement of circumferential margin, relationship of tumor to peritoneal reflection and effects of neoadjuvant therapy. Routine pathological report should be adequate and it remains the main arbiter of management, prognosis, surgical quality assessment and gives us an opportunity to compare the results.

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From pharmacogenomics to surgigenomics: Is it the new frontier for determining ultimate procedure in bariatric/metabolic surgery?

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Obesity is the second leading cause of death and it considerably increases the risk of other co-morbidities such as metabolic syndrome, cardiovascular diseases, type-2 Diabetes Mellitus (T2DM), non-alcoholic steatohepatitis, dyslipidemia, sleep apnea and infertility. For the last quarter decade, bariatric-metabolic surgery has justified its role for treating this multi-factorial disorder with substantial resolution of above-mentioned co-morbidities. Here-in, we will discuss recent data on proteomics, metabolomics and transcriptomic associated with bariatric/metabolic surgery and we will concentrate on a new terminology which covers all this omics research and personalized therapy options before and after bariatric/metabolic and other surgeries named as surgigenomics. Surgigenomics is a new terminology and differs from pharmacogenomics in certain aspects. It is the study of the role of genetics to surgical response in effect of time. There is no drug response or alteration of protein or nucleotide synthesis due to the chemotherapy. The whole effect to genome is being done by the alteration of anatomy and hormonal response of the body as a result of surgical procedure. Surgigenomics is important for personalized therapy because of the following reasons: Like every other drug there are different surgical options for the treatment of morbid obesity and T2DM. These options vary substantially due to patients' weight and metabolic state. If patients can be screened by whole genome sequencing before surgery, more focused surgical option can be determined for the vulnerable individual and this option can be more durable in future for controlling the metabolic state of the individual. Also recent studies done in pre and post bariatric surgery; patients involving in transcriptomics has led promising results for targeted drug therapy leading many data on expression of several genes involved in inflammation, insulin sensitivity in muscle, adipose tissue and hematopoietic stem cells. The discoveries from these RCTs encouraged us to open up a new field of surgigenomics and gave us hope for future personalized options of metabolic-bariatric surgery which may lead to targeted drug therapy in obesity and metabolic disorders.

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CMV colitis

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Introduction: CMV colitis is an inflammation of the colon. The infection is spread by saliva, urine, respiratory droplets, sexual contact, and blood transfusions. Most people are exposed to the virus in their lifetime, but it usually produces mild or no symptoms in healthy people. However, serious CMV infections can occur in people with weakened immune systems. This includes patients receiving chemotherapy for cancer and patients on immune-suppressing medicines following an organ transplant.

Microbiology: Cytomegalovirus (CMV) is a member of the Herpesviridae. It is a double-stranded DNA virus with a protein coat and lipoprotein envelope. Similar to other herpes viruses, CMV is icosahedral and replicates in the host's nucleus. Replication in the host cell typically manifests pathologically with large intra-nuclear inclusion bodies and smaller cytoplasmic inclusions, and is accompanied by the presence of CMV viral particles in the plasma.

Case Report: 61 year old Chinese female with background history of known primary hyperthyroidism (Grave disease) and autoimmune hepatitis was hospitalized with altered mental status. She was managed as grade-3 hepatic encephalopathy; she developed massive haematochezia and underwent sigmoidoscopy which showed no active bleeding. She was stabilized in intensive care unit. She once again had PR Bleed and underwent CT angiogram which was normal. She underwent colonoscopy which showed 2 clean based ulcers in transverse and sigmoid colon. CMV DNA was positive and was referred to infectious disease and she was managed as CMV Colonic ulcers and was started on valgancyclovir and she clinically improved.

Discussion: The drug of choice for treatment of CMV disease is intravenous ganciclovir, although valganciclovir may be used for non-severe CMV treatment in selected cases. CMV colitis in the immune-competent patient is uncommon, though it has been described as presenting with a syndrome incorporating symptoms of colitis (e.g. abdominal pain, fever, diarrhea, rectal bleeding). The vast majority of CMV colitis cases occur in patients who are immune-deficient, particularly those who have deficiency in cell-mediated immunity. Thus CMV colitis is often seen affecting patients with acquired immune deficiency syndrome, organ transplant recipients, patients taking immunosuppressive medications, those undergoing chemotherapy and/or radiation therapy, and elderly patients, particularly those who suffer from chronic disease.¹ Although the clinical history might help in identifying patients at risk of developing CMV colitis, sometimes the disease may occur without a predisposing clinical background. With respect to colonic involvement, difficulty arises in establishing the clinical diagnosis of CMV colitis when the infection overlaps with idiopathic colitis.

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Evidence based mini-laparoscopy - Small instruments, big surgeries

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Background: Stigmatized as expensive, time consuming and complicated, mini-laparoscopic surgery seemed to have no major advantages and did not progress the way industry had imagined. In Brazil, with various adjustments in the MINI original technique, several procedures have been developed where great results are achieved using simple and more reliable mini low friction reusable instruments.

New MINI instruments: In order to improve movement precision and decrease surgical stress, a no seal and no valve trocar (low-friction) was developed, minimizing usual friction forces. The special MINI trocar was designed to resemble a long needle, matching the diameter of the corresponding 3mm instruments. Free left lumen is minimal, therefore eliminating the need for sealing to prevent gas loss. The long trocar dilating tip significantly improves cosmesis, while prevents dislocation of the cannula even in thin patients and emphasizes the idea of a less scar and less trauma approach.

MINI cliplless cholecystectomy: The problems of the MINI optics were solved by simply not using it. Knots are tied to the cystic duct and the cystic artery is cauterized. This technique has been described in detail in a publication of 1000 cases without mortality, conversion to open surgery or common bile duct injuries. In order to avoid the use of mini-scopes, gallbladders were removed in bags and most of the cases were discharged in less than 24h with virtually no pain.

MINI inguinal hernia repair: The hybrid mini-laparoscopic TEP-TAPP, combining features and advantages of each technique with the delicacy and precision of the MINI instruments, appears simple, safe and versatile. Reducing costs since this technique obviates the need for using balloon dissection and mesh fixation. A reduced learning curve can also be found since mini preperitoneal dissection allows faster and easier creation of the preperitoneal space.

Conclusion: Other MINI advanced endoscopic procedures have also been regularly performed in Brazil, including thorax and lumbar sympathectomies, trans-anal endoscopic operations (TEO), Nissens, appendectomies, adrenalectomies, right and left colectomies, splenectomies, lymphadenectomies, bile ducts explorations and reconstructions, not to mention several gynecological and urological procedures. In short, cheaper is not necessarily worse and recognized benefits were found in the Brazilian MINI technique which is a 1-day surgery, safe, with all the advantages of laparoscopy, highly reproducible, cost effective and with great aesthetic appeal.

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Endoscopic management of gastro-esophageal reflux disease GERD

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Gastro-esophageal reflux disease (GERD) is a complex disorder resulting from multiple contributing factors, including acid production, lower esophageal sphincter tone and location, and anatomic barriers to reflux created by the angle of His and the diaphragmatic hiatus. The high prevalence of (GERD) together with drug dependence, intolerance and side effects was the driving force for development of interventional procedures. The laparoscopic fundoplication was the only option for many years in spite of being unfavorable by the patients. The unchallenged practice released many reports of various types of complications and unwanted results. That paved the way for emerging of less invasive trans-oral endoscopic procedures for (GERD). The three available competing techniques are Stretta, Esophyx and MUSE. Every procedure is evolved during the last years into new generations with more safety and efficacy after many modifications in precision. Size and quality of tool, the decision to do endoscopic management and choosing between the available procedures should be perfectly tailored to individual patients. The interpretation of symptomatology score and Endoscopic findings together with high resolution manometry HRM and 24 hour impedance PH metry results decides the treatment path for the patients. A major guidelines shift occurred in the last years towards endoscopic management of GERD. Some limitations have been set for such managements as the age and size of hiatus hernia, however defective esophageal clearance is not very much an obstacle as in the case of Nissen fundoplication. Many factors affecting the contradicting outcome reports about efficacy of each procedure, collecting subjective and objective measurements for every procedure will help for prioritization and setting standards of care for GERD, the procedures have financial obstacles towards wide range application for patients.

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Ecosystem versus dysbiosis who, where and what?

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In ecology, an ecosystem refers to the combination of a community of living creatures and their environment (the biotope). Our intestine contains numerous ecosystems. The human gut microbiota is made of just over 1,000 species of bacteria. Each of us is host to more than 200, and each individual has his or her own unique microbiota. Despite a high biodiversity, they serve a very similar role from one healthy person to the next. The total sum of genes within our gut microorganisms known as metagenome has a genetic potential 100 times higher than that of human genome. They control a whole range of physiological and sometimes pathological functions i.e. balanced ecosystem that constantly regulates itself. The fragile balance may be upset if the microbiota comes under attack and the term dysbiosis was introduced and the imbalance was associated with harmful consequences for the host. After many research into gut microbiota, it becomes much easier to explain "Gut microbiota: Who are you, where are you and what are you doing".

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Primary gastric yolk sac tumor with liver metastases in a 66-year-old patient: A case report

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Yolk sac tumor (YST) of the stomach is extremely rare, with only several cases reported in the English literature. We present a case of primary gastric yolk sac tumor with liver metastases in a 66-year-old male. Preoperative diagnosis was poorly differentiated as adenocarcinoma of stomach. A total gastrectomy was performed. The tumor, with a maximum size of 6.0 cm, was composed microscopically of neoplastic cells with pale eosinophilic cytoplasm. Tumor cells were arranged into solid and papillary structures with several Schiller-Duval bodies. Other components of germ cell tumors, such as embryonal carcinomas and choriocarcinoma, were not identified. The tumor cells were positive for AFP, CK 18, CK 20, SALL4, glypican3, but were negative for PLAP, OCT 3/4, CK 7 by immunohistochemistry. The surgical margins were histologically negative, 12 of 22 resected lymph nodes had metastases. The laboratory findings showed high serum levels of AFP (2502ng/mL); testicles were symmetric with normal size. Primary pure gastric yolk sac tumor is a very rare entity. The rarity of gastric YST makes this diagnosis complicated. However, awareness of this unusual entity and its distinctive immunohistochemical profile invariably leads to a correct diagnosis.

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Hybrid minimally invasive esophagectomy - Combining both open and minimal access to bridge the learning curve

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The rise of minimally invasive surgery since the past decade has seen the trend of management of surgical condition towards more minimally invasive approach. The favor on the side of minimally invasive procedures is obvious with the potential benefits of lesser post-operative pain, reduced length of stay and wound complications. However, in procedures such as esophagectomy, gastrectomy and Whipple's procedure which is technically more demanding when performed via the minimally invasive approach, we have not seen a great rise in numbers. Multiple recent clinical studies have shown the benefits in minimally invasive esophagectomy and the oncological outcomes are not compromised. As there is a learning curve to this procedure, we proposed a hybrid approach to reduce the operative time for surgeons embarking on this approach.

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Metabolic surgery in uncontrolled and poorly controlled type 2 diabetes mellitus

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Every bariatric surgical procedure currently being practised globally, also has metabolic advantages to varying extents according to the procedure, and generally depends on the extent of malabsorption induced by the procedure. Thus, BPD-DS procedure has shown the best remission and resolution rate among all the bariatric procedures. But the nutritional and other complications have prevented it from becoming a gold-standard procedure. The June 2016 issue of diabetes care has listed a set of 32 recommendations related to the use of metabolic surgery for treatment of type 2 diabetes. These are supported by high quality evidence, including RCTs and systematic reviews/meta-analyses that show dramatic and durable improvement in T2DM. The biologic rationale is based on the recognition of an important role of the gut in metabolic regulation and directly on glucose homeostasis. Thus, bariatric procedures are effective in diabetes and have changed the landscape of diabetes care. Strong evidence now demonstrates that procedures designed to be essentially metabolic like the ileal transposition which have minimal bariatric effects and do not cause any significant malabsorption, are showing great promise in the long-term resolution and remission of type 2 diabetes in patients with a BMI <35 kg/m². There is now level 1A evidence that surgery is superior for T2DM remission, glycemic control and HbA1C lowering, for selected patients with a BMI <35 kg/m².

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Metabolic surgery for low BMI type 2 diabetes

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Asians develop type-2 diabetes at a lower BMI because of their genetic propensity to have more visceral fat for their BMI range. It is no longer believed now that the reversal of diabetes after metabolic surgery is due primarily to weight loss and there is now much data showing that diabetes reverses quite quickly after surgery before much weight loss has occurred. Clearly hormonal mechanisms are at play, some of which have been worked out and others remain to be discovered. It is also no longer in doubt that bypass operations have a stronger anti-diabetic effect although a sleeve resection does an adequate job in the obese and overweight patient. In this small series of 60 patients, we document the results of an unselected group of low BMI patients operated mainly with the goal of improving or reversing their type-2 diabetes. We define full reversal as those who get off all medications including insulin and are able to document HbA1C result of 6.5% or below. We collected 60 patients of average age 50.3 years (Range 33-64 years). There were 34 males and 26 females. Duration of diabetes averaged 8.3 years. 22 were on insulin and 38 were only on oral medication. Average blood sugar before surgery was 9.5mmole/l. Average weight of patients before surgery was 78.59 Kg (Range 51.5 Kg to 126.7 Kg). BMI before surgery was 28.99 Kg/square meter. (Range (18.7 to 37.66)). 18 patients had BMI 27 or under and only 4 patients had BMI more than 35 Kg/square meter. Pre-operative C-peptide level was 2.4 UG/L (Range 0.75 to 4.5). All patients who were obese with BMI around 27 or above had a laparoscopic gastric sleeve resection. Those under BMI of 27 had a Roux-en-Y gastric by-pass or Mini-by-pass. The bypass was modified to minimize the weight loss effect of the operation. Average blood sugar before the surgery was 9.57 (mmole/l), this dropped to 6.03mmole/l after this operation. The difference was 3.28 mmole/l. After an average of 18 months follow up, (90%) were off-all medication, 6 patients (10%) were still on oral medication but were off insulin. Patients who were previously only on oral medication were all off diabetic medication. Of the 6 patients who are still on medication 4 are in the below BMI 27 kg/square meter group. This gives a success rate in this very low BMI group of 77%. Success rate in the above BMI 27 group was 95% (40 of 42 patients). Average HbA1C before surgery was 8.02%. All of these were despite medication or insulin. Average HbA1C after surgery was 5.9% (Range 4.9 to 6.8%). The average drop in HbA1c was 2.9%. Average weight of patient after the surgery was 62.27kg (Range 46.7 kg to 91.5kg). Average weight loss was 12.5kg (Range 6.3kg to 22.1kg). No patient became excessively underweight after the surgery. We strongly believe that the effect of metabolic surgery on type-2 diabetes is independent of start weight or weight loss and that BMI should no longer be considered in evaluating patients for metabolic surgery. There should not be any fixed lower BMI for doing this surgery.

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Advanced laparoscopic surgical management of biliary and pancreatic disease: An overview

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Diseases of the biliary system and pancreas like all other organs range from simple to complex disorders and can be benign or malignant. They could vary from a simple cyst to periampullary carcinoma and pancreatic head malignancies. Traditionally the management of these disorders has been by conventional open surgery. The post operative morbidity has been reported to be high and there is a significant mortality too. Certain disorders like infected pancreatic necrosis requiring necrosectomy usually have a poor prognosis. The large incisions and blood loss and post operative pain add to the morbidity of the disease. The introduction of laparoscopic surgery is a boon to the surgical field. The procedures which are performed by open surgery can be done as good if not better by laparoscopy. The morbidity and mortality are greatly reduced. Procedures such as Puestows and Whipples done by open surgery have a significant post operative morbidity. All these major pancreatic surgeries can nowadays be done by laparoscopic and robotic surgery. The use of minimal access technique in the management of pancreatic and biliary diseases greatly reduces the post operative morbidity and mortality. However significant expertise and experience is required for the performance of these procedures.

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Single incision laparoscopic surgery: Principles and practices

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Single Incision Laparoscopic Surgery (SILS) is a new age laparoscopic technique where laparoscopic surgery will be performed through a single port rather than three or more ports as in conventional laparoscopy. Though it had initial popularity, it failed to impress the surgical community due to its ergonomic difficulty. Feasibility of various procedures is tried in multiple centers and the ergonomics are modified accordingly. Although results are similar to laparoscopy, SILS has its limitations like not possible for all laparoscopic surgeries with the present available instruments, more time consuming, difficult traction techniques and ergonomic limitations. However, early results are promising under technically strong hands and it is already proved beneficial in few procedures like fundoplication, hysterectomy, splenectomy, sleeve gastrectomy, etc. Various ergonomic and instrument modifications are tried and postulated for the same including numerous ports to enhance the performance. However, ergonomic modifications in line with the principles of laparoscopy and instrumentation are mandatory for effective performance. With the recommendations of ergonomic modifications and liver and organ transplantation techniques as per authors experience and research, even complex advanced minimal access surgeries like gastrectomy, colectomy, gastric bypass, etc can be achieved by SILS technique. The recommendations include the ideal SILS port, instruments, planes of instrumentation for dissection and manipulation during the procedures. With the possibility of more new generation instruments to come, SILS is all set to replace laparoscopy in selected cases. However, long term multi-centric studies are required to prove the advantages over conventional laparoscopy.

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Cancer in the Democratic Republic of Congo (DRC)

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In the Democratic Republic of Congo (DRC), cancer kills more than tuberculosis, AIDS and malaria combined. Its prevalence is rising steadily as in the rest of the world. In the West, cancer, the leading cause of death, is responsible for more than half of the deaths, even if it is declining. In 2008, nearly 44% of deaths in hospitals in the DRC were due to cancer according to the Ministry of Health. This steady rise in prevalence concerns chronic noncommunicable diseases, among which cancer takes a large place. Favorable factors include dietary habits, lifestyle changes, etc. In fact, cancer results from the combination of several factors, some of which are preventable, such as smoking, alcohol abuse, exposure to infections such as AIDS, hepatitis B and C, papillomavirus. Exposure to cervical and anal cancer, abuse in the consumption of fats, lack of physical exercise, non-consumption of vegetables and fruits. This world scourge spares no one because of age, sex, race, religion, wealth or poverty. It must be considered as a major public health problem. The most frequent cancers in man affect the lungs, the prostate, the colon; and in the woman, the breasts, the lungs, the colon. On the digestive level, in the DRC, the rise appears to be regular for cancers of the liver, stomach, large intestine, rectum; Perhaps contributing to a life expectancy of the Congolese (51) among the lowest in the world, lower than the African average (56 years), very far from the French figures (78 years for men and 83 years for women). It is estimated that nearly 12.4% of the 804 million people in the African Region will develop cancer before reaching the age of 75 years. The risk increases with age, and 90% of cancer cases will occur after the age of 40 years. If action were taken immediately, there could be an annual saving of some 100,000 lives by 2020. Indeed, two thirds of cancers are curable, provided they organize screening and diagnosis at an early stage, and to benefit from the appropriate treatments. The absence in the DRC of a national cancer registry, statistics and a formal cancer control program is a shortcoming that needs to be corrected quickly. We must therefore work towards a national awareness of the reality of cancer; the commitment of the Ministry of Public Health in the fight against cancer is unavoidable. According to the WHO Regional Director for Africa: "Governments and development partners have a shared responsibility to raise awareness to dispel prejudices and preconceptions about cancer and to promote change in life and behavior related to the risk factors of this disease". There is a need for the DRC to organize care in oncology. This implies: 1. Training of health professionals in the management of cancer; 2. Development of structures adapted to the management of cancer; 3. Information campaigns aimed at the general public; 4. Mobilization of financial resources; 5. Access to anti-cancer drugs, perhaps in the anti-retroviral model for HIV. In conclusion, cancer represents in DRC, an increasingly important cost, in terms of human lives; it becomes urgent to organize its care.

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62 digestive and accessory cancers seen in 1 year at the Marie-Yvette Clinic in Kinshasa, Democratic Republic of Congo

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Introduction: As in the rest of the world, the prevalence of cancer is increasing in the Democratic Republic of Congo (DRC). However, in the absence of a national cancer registry, there are no reliable figures that would allow studies to be carried out in order to improve the care of the patients concerned and to contribute to the training of young people in oncology.

Aim: The aim of this retrospective, documentary and mono-centric study was to document the cases of digestive cancers received at a center specializing in digestive pathology, the first of its kind in the DRC, since its opening in June 2015; And to analyze the frequency thereof.

Methods: All cases of digestive or ancillary cancers seen between June 2015 and May 2016 were retained. The parameters analyzed were age, sex, diagnosis.

Results: The diagnosis of digestive cancer was established in 62 patients. There were 40 men and 22 women, with a sex ratio of 1.81. The mean age was 57.7 years; with extremes of 24 and 91 years. The distribution of cancers is shown in table no. Colorectal cancer in 20 cases out of 62, or 32%, of hepatocellular carcinoma in 12 cases, 19%, stomach cancer in 6 cases, 9.6%, stromal tumors in 5 cases, 8%, pancreatic cancer in 5 cases, 8%, cholangiocarcinoma in 3 cases, or 4.8%, hepatic metastases of non-digestive primitive in 6 cases, or 9.6%, and "others" Tumors in 4 cases, or 6.4%.

Table: Breakdown and frequency of cancers.

Diagnostic	Number /62	%
Colorectal cancer	20	32
Hepatocellular carcinoma	12	19
Stomach Cancer	06	9,6
Stromal tumors	05	8,0
Pancreatic cancer	05	8,0
Cholangiocarcinome	03	4,8
Hepatic metastases of non-digestive primitive	06	9,6
Other	4	6,4

Conclusion: Digestive and ancillary cancers are a reality in the DRC. In this preliminary series, colon cancer was more common followed by hepatocellular carcinoma and stomach cancer.

The mean age of the patients was 57.7 years with a male predominance. It is urgent to organize the management of these pathologies in the DRC.

(1) The global burden of cancer 2013, Jama Oncology, 28 May 2015

(2) Congolese Minister of Public Health, Dr Félix Kabange Numbi, Awareness Day Against Cancer, 04/02/2008.

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NAFLD severity and insulin resistance

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NAFLD has become the most prevalent cause of liver disease worldwide, parallel with the dramatic rise in population levels of obesity and diabetes. Twenty-six percent of all patients with NAFLD have been reported to develop liver cirrhosis over a 10-year period, and about 12% of the patients with NAFLD die of liver-related causes. It is expected, by the end of this year, 2016, that the number of overweight subjects exceeds 2.8 billion. More than 30% of Western population, 70% of diabetic individuals, and 95% of morbidly obese patients, will present steatosis. Insulin resistance is a consistent finding in patients with IGT, and T2DM, and resistance is present years before the onset of diabetes. Elevated FFAs predict the progression from IGT to diabetes. Insulin sensitivity is influenced by a number of factors including age, weight, ethnicity, body fat (especially abdominal), physical activity and medications. Up to 85% of subjects with NAFLD compared to 30% in normal population are insulin resistant and have abnormal glucose metabolism (pre-diabetes or T2DM) of which they were unaware. In Egypt (2005-2006), we had studied 495 over weight and obese patients. NAFLD is diagnosed by ultrasound elevated liver enzymes. NAFLD prevalence in patients with metabolic syndrome was 65% in males and 55% females. In Egypt (2013-2014), we had worked on 100 overweight and obese patients (BMI 34.9 ± 3.8), patients preliminary diagnosed as NAFLD by liver ultrasound, followed by liver biopsy to assess the presence of NASH. All the participants had NAFLD 100%. The most surprising was; 46% of the patients had NASH (44.1 ± 7.1 year, ALT 37.2 ± 21.2), 44% border line NASH (43.1 ± 7.9 year, ALT 30.7 ± 17.2), while only 10% had simple steatosis (45.1 ± 4.6 year, ALT 21.2 ± 7.4). NAFLD associated significantly with a high level of insulin resistance in obese non-diabetic Egyptian patients compared with participants with normal liver; HOMA-IR (4.54 ± 0.99 vs. 3.303 ± 0.90 , $P=0.000$). HOMA-IR showed a significant positive correlation with the severity of fatty liver. Surprising outcomes: liver ultrasound not only predict the amount of steatosis but can be a very useful non-expensive screening tool of identification of NASH patients, and high levels of plasma insulin and an unsuspected very high HOMA- IR index in Egyptian NASH obese patients with normal FPG was observed. There are many questions that need to be answered: Is the ethnic variations can affect HOMA-IR to that extent?, Mean that every country populations should have their HOMA-IR cut-off values for diabetics and non-diabetics, and Can HOMA-IR level predict the severity of NASH as a simple low cost noninvasive screening method?

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Intra gastric balloon success or satisfaction

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Introduction: The WHO recorded that nearly two third of people in Iraq were overweight and obese; the placement of intra-gastric balloon (IGB) constitutes a short term, effective, nonsurgical intervention to lose weight.

Objective: This study was performed to assess the safety and effectiveness (success or satisfaction) of 566 patients with IGB to treat obesity.

Methods: This was a prospective clinical case series study which includes 566 patients for whom IGB (520 Medsil, 35S patz3, 8 Endalis and 3 Heliosphere) introduced, the safety assessed for all while the effectiveness assessed for 320 patients.

Results: 320 patients (245 females and 75 males), their age 14-64 (mean 35 years) underwent the procedure and their balloon removed after 4-13 months average 7 months (for the recommended 6 months balloon) and 3-16 months (spatz3). The average weight obtained was 132 (76-209 kg). The patient lost 3-76 (average 22 kg which was equal to 4.3-114.2 (average 31) percent of excess weight. Their BMI reduced was 0.6-21 (average 8.5 kg/m²). Their associated comorbidity improved after weight loss and the quality of life improved in 76% of patients depending on bariatric analysis and reporting outcome system (BAROS). We recorded 2 cases of mortality from 566 (0.35%) in extreme obesity, these mortality were not related to balloon itself but to the associated morbidities.

Conclusions: Obese and morbidly obese patients can reduce their weight effectively by the simple procedure of IGB and although this procedure cannot be regarded as successful (31% EWL), but many patient are satisfied with it and their quality of life improved (satisfied) with decrease in their morbidity.

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Ambulatory colorectal disease: A vision for the future or already here?

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The author will start by defining ambulatory care particularly in the sphere of colorectal disease. We will present what is available now worldwide but focus on current UK practice and the evidence for it. An economic model is presented for typical ambulatory colorectal services (ACS) in the NHS. The current and proposed structure of ACS will be summarized including integration with gastroenterological, endoscopic, radiology and day surgery services for minor coloproctological procedures. In addition, a model of care for re-sectional surgery is presented encompassing patient selection, the tenets of enhanced recovery in surgery (ERAS), laparoscopic surgery, pre, peri and anesthetic care, 24 hour surgery wards, 2-5 day surgical facilities and integration with community or 'hotel' based services. The role of multi-disciplinary teams (MDTs) in the management of ACS is discussed: core and extended members of the MDT defined and the overall focus on patient directed care. Current and future directions in provision of ACS will be summarized with focus on use of virtual technology to establish clinics and MDTs; social media; the increasing role of e and mHealth will be presented. A future patient focused clinical and economical model of ACS will be proposed with relevance for it in different health care systems

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Prevalence of steatosis and advanced liver fibrosis in infected patients with HIV Bukavu Provincial Hospital: Preliminary study

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Introduction: Today, there is an increase in the prevalence of fatty liver including in people infected with HIV (PHIV) worldwide.

Objectives: To assess the prevalence and risk factors associated with fatty liver in PHIV tracked Bukavu general reference to provincial hospital (HPGRB) and to determine the prevalence of advanced liver fibrosis in these patients.

Method: It is a cross-sectional study conducted from March 5 till November 20, 2015 which included 70 patients infected with HIV as they presented themselves to the HPGRB during the study period. All realized abdominal ultrasound with CHISON i3 or SONOSCAPE S11 device with a convex probe of 3.5 MHz in addition to laboratory tests to calculate the NAFLD fibrosis score online.

Results: Majority of our study population was aged over 35 years (74.3%) with a predominance of males (58.6%). 10% were overweight; 20% had a moderate alcohol consumption; 1.4% had diabetes; 38.5% were clinical stage 3 of the WHO and 8.7% in stage 4. The median CD4 count was 124 (19-618) cells / microliter. 62.9% of patients were treated with AZT+3TC+NVP; 10% in TNF+3TC+EFV; 7.1% for EFV+TNF+EMTRIC. The prevalence of hepatic steatosis was 59.2% and 14.2% of patients had advanced liver fibrosis. Factors associated with steatosis were an albumin level of less than 3.5 g/ dL OR=10.8 (1.5 to 264.6) p=0.02; elevation of alanine aminotransferase (ALT) OR=3.2 (1.1 to 9.8) p=0.02.

Conclusion: Prevalence of hepatic steatosis in our study population was high (59.2%). Hypo albumin and ALT elevation are biological factors associated with the presence of this steatosis (p=0.02).

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