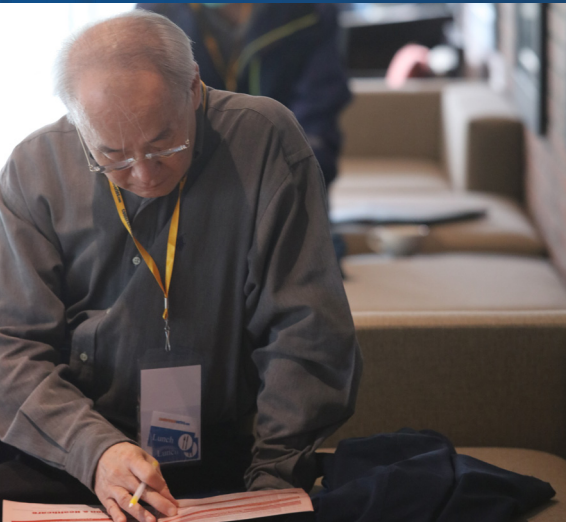


16th International Conference on

GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE



Scientific Tracks & Abstracts (Day 1)

GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Laparoscopic sleeve gastrectomy and GERD

Safwan AbdulRahman Taha
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Since its introduction, Laparoscopic Sleeve Gastrectomy (LSG) has always been criticized for its unfavorable effect on Gastroesophageal Reflux Disease (GERD) and/or causing it with conflicting reports in this regards. This presentation reviews data form the published international literature to delineate the effect of LSG on pre-existing GERD as well as its role in the development of new GERD symptoms following surgery with comparison of the effects of Roux-en-Y Gastric Bypass (RYGB) on both aspects of GERD. Possible causes of the pattern of LSG's involvement with GERD are also discussed along with suggested solutions and the medical and surgical management of GERD following LSG are outlined in details too.

Biography

Safwan AbdulRahman Taha has completed his Graduation from Basrah College of Medicine on 1983 with honors where he became Professor of Surgery, on 2000 and then founding Dean of Thi Qar College of Medicine (Iraq, 2003). He holds Fellowship of the Royal College of Physician and Surgeons of Glasgow, Fellowship of the American College of Surgeons, Diploma laparoscopic Surgery from Strasbourg University; France and Certificate of the Arab Board of Surgery. He is currently Governor of the UAE Chapter of the American College of Surgeons, Member of the Board of Governors of the American College of Surgeons, Member of the International Relations Committee of the American College of Surgeons and Vice President of the Emirates Society for Laparo-Endoscopic Surgeons. He is an international speaker and has more than 37 published papers. He is the Medical Director and Director of the Bariatric and Metabolic Surgery Center, Mediclinic Airport Road Hospital, Abu Dhabi; UAE.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Gohary's disease

Amin Gohary
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Gohary's disease is a new phenomenon that has not been described before. It depicts a group of children who present to emergency department with severe agonizing abdominal pain. The pain tends to start and ends abruptly, no predisposing factor and recurs after minutes or hours. Ultrasonography revealed mesas at right iliac fossa, which is usually diagnosed as intussusception. The underlying cause of such phenomenon is the fecal impaction of stool at terminal ileum which acts as intermittent intestinal obstruction. We have encountered 19 cases over the last 5 years, their age varied from 9 months to 8 years with the majority under the age of 2 years. The cardinal symptoms and signs are: (1) Severe abdominal pain that warrants urgent attention, (2) empty rectum on examination and (3) ultrasound diagnosis of intussusception. All of these cases were managed by fleet enemas with immediate response. Awareness of this condition will help to avoid unnecessary investigation and unjustified exploration.

Biography

Amin Gohary completed his MBChB in 1972 and his Diploma in General Surgery in 1975 at Cairo University, Egypt. He became a fellow of The Royal College of Surgeons in UK: Edinburgh in 1979, London in 1980, and Glasgow in 1997. Prof. Dr. Amin worked initially in Egypt, then moved to Kuwait, then to UK, before coming to UAE in 1983. In the same year, he became the Chief and Head of the Department of Pediatric Surgery of a large government hospital. Additionally, he held post as a Medical Director for the same hospital starting 1989. He was appointed as Chief Disaster Officer during Gulf War in 1991. He also held post as the Clinical Dean of Gulf Medical College, Ajman for 3 years. Prof. Dr. Amin is well known in Abu Dhabi for his extensive interest and involvement in scientific activities. He is the President of the Pediatric Surgical Association of UAE. He was awarded the Shield of the College of Pakistan in 1996 and the Medal of International Recognition in pediatric urology from the Russian Association of Andrology in 2010. He was given a Silver Medal from the Royal College of Surgeons – Ireland in 1978 and an Honorary Fellowship from the Royal College of Surgeons – Glasgow in 1997. In 2001, he became a Visiting Professor at Munster University, Germany. Prof. Dr. Amin is a member of several associations in pediatric surgery: Executive Member of the International Society of Intersex and Hypospadias Disorder (ISHID), British Association of Pediatric Surgery, Egyptian Association of Pediatric Surgeons, Asian Association of Pediatric Surgeons, and Pan African Association of Pediatric Surgery. He is also the founder and member of the Arab Association of Pediatric Surgeons. Prof. Dr. Amin has an intensive academic and teaching experience, has written several publications in distinguished medical journals, and has made several poster and paper presentations in national and international conferences. Currently, he is an external examiner for the Royal College of Surgeons.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Laparoscopic pancreatic surgery

Ritu Khare

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Pancreatic surgery is associated with a relatively high morbidity and mortality compared with other abdominal surgeries. This is a result of the complex nature of the organ, the difficult access as a result of the retroperitoneal position and the number of technically challenging anastomoses required. Nevertheless, the past two decades have witnessed a steady improvement in morbidity and a decrease in mortality achieved through alterations of technique (particularly relating to the pancreatic anastomoses) together with hormonal manipulation to decrease pancreatic secretions. Recently minimally invasive or laparoscopic pancreatic surgery is now being performed in specialized HPB units around the world with results comparable to open surgery and lesser morbidity. While practically all pancreatic surgeries can be done laparoscopically, the most common procedure performed is a laparoscopic distal pancreatectomy, because of the more straightforward nature of the resection and the lack of a pancreatic ductal anastomosis. Laparoscopic distal pancreatectomy is usually performed for tumors in the distal body and tail of the pancreas. Laparoscopic lateral pancreaticojejunostomy is also commonly done for patients with chronic pancreatitis with a dilated main pancreatic duct. Laparoscopic pancreaticoduodenectomy or Whipple's procedure is also possible in experienced centers in selected group of patients with periampullary tumors. The results are equivalent or better than those associated with a traditional approach. One of the areas where the minimally invasive approach has been found to be exceptionally useful is in patients with necrotizing pancreatitis who require necrosectomy. A laparoscopic approach for necrosectomy is much safer and carries far less morbidity than the traditional open necrosectomy. The procedure can be done multiple times to clear the necrotic areas and drain the infection. This technique has also been shown to reduce surgery related mortality in this group of patients. The talk will focus on the current evidence base for increasing the use of laparoscopic pancreatic resection and will highlight challenges and other aspects that must be considered before adapting to this technique.

Biography

Ritu Khare is an accomplished surgeon practising in the UAE for the last 12 years. She is an expert in laparoscopic abdominal surgery, bariatric surgery, colorectal surgery, hernia surgery and all forms of breast and thyroid surgery. She has done her Masters in General Surgery from the renowned King Edward Memorial Hospital in Mumbai, India followed by a specialization in Gastrointestinal Surgery from the Sanjay Gandhi Postgraduate Medical Institute at Lucknow, India. She is a member of the Royal College of Surgeons of Edinburgh. In 2017 she was conferred upon the Fellowship of the American College of Surgeons (FACS). She has a vast experience in laparoscopic abdominal surgery having trained at the Institute of Laparoscopic Surgery at Bordeaux, France.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Eosinophilic esophagitis: Updates in 2018

Seema Khan

Children's National Medical Centre, USA

Definition and Epidemiology: Eosinophilic Esophagitis (EoE) is a chronic immunologic disorder characterized by esophageal dysfunction and dense eosinophilia confined to the esophagus. It has been reported from most continents, with higher prevalence in Western than Eastern countries. It predominantly affects Caucasian males. Current prevalence is estimated as 0.5-1/2000 and incidence 5-10/100,000 in US and Europe.

Pathophysiology: EoE has a strong heritability pattern with a 58% concordance rate in monozygotic twins and relative risk of 64% amongst brothers. Many genetic susceptibility elements have been identified including 5q22 at TSLP and 2p23 at CAPN14. These interact with antigen exposure in the form of food and inhalants, and microbiome leading to activation of T helper type 2 cell line of cytokine production including TGF β , IL-4, IL-13 and IL-5, thus producing epithelial barrier disruption, eosinophilic inflammation and remodeling. Conceptually, untreated or suboptimally treated EoE progresses from the stage of chronic inflammation to fibrostenosing, producing obstructive sequelae, often in the absence of stenosis and strictures.

Evaluation:

- Clinical presentations: EoE is clinically suspected in younger children with regurgitation, vomiting, feeding difficulties, and in adolescents and adults with dysphagia and food impaction. It is the most common cause of food impaction. Higher rates of atopic disease such as asthma, atopic dermatitis and hay fever are observed in EoE patients.
- Diagnosis is established by an upper endoscopy with esophageal biopsies showing at least 15 eos/hpf in the appropriate clinical context. Endoscopy features are classically edema, and exudates, notable in the early inflammatory stage, and furrowing, rings and strictures with progression to subepithelial fibrostenosis. A trial of proton pump inhibitor (PPI) therapy does not reliably exclude GERD and hence is not required before the endoscopy. An esophageal impedance offers further investigation of GERD as warranted.
- An esophagram is important when differentiating from anatomical abnormalities and achalasia.
- Endoscopic functional lumen imaging probe (FLIP) is a novel technique that is now being applied to measure esophageal distensibility and in the future may be an adjunct test in the assessment of EoE disease activity.
- Cytosponge and string test are being investigated as less invasive methods for esophageal samples.

Management: Standard therapies include elimination diets, topical steroids and PPI. Investigational agents include anti-IL-5, anti-IL-13, anti-IL-4 and IL-13, anti-mast cells and anti IgE.

Elimination diets: Removal of key food allergens (milk, wheat, eggs, soy, peanut, tree nuts, fish, shell fish) is the basis of empiric 6, 4 and 2 food elimination, yielding 74/81%, 54/64%, and 40/44% success in adults and children respectively. The 2-4-6 start up study has shown earlier detection of triggers, and less endoscopies.

Topical swallowed steroids: The conventional formulations are swallowed fluticasone, and budesonide slurry, with success rate of 50-80%. Recently, orodispersible budesonide tablet has demonstrated achievement of overall histological remission of ~85% at 12 weeks when use was extended from 6 to 12 weeks in non-responders.

PPI: It is now known that patients with EoE have clinical and histologic response to PPI independent of their GERD status. Induction is usually achieved with a high dose PPI regimen for 8 weeks, followed by a lower dose for maintenance of remission. 70% children with initial PPI response maintained symptomatic and histologic remission at 1 year on a low PPI dose.

Biography

Seema Khan is a pediatric gastroenterologist in Washington, District of Columbia and is affiliated with multiple hospitals in the area, including Children's National Medical Center and MedStar Georgetown University Hospital. She received her medical degree from Aga Khan Medical College and has been in practice for more than 20 years. Dr. Khan accepts several types of health insurance, listed below. She is one of 14 doctors at Children's National Medical Center and one of 14 at MedStar Georgetown University Hospital who specialize in Pediatric Gastroenterology.

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August 06-07, 2018 Abu Dhabi, UAE

Prevention of post-surgical recurrence of Crohn's disease

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Statement of the Problem: Postoperative recurrence of CD is common; rates may vary depending on definition used. If untreated endoscopic recurrence will be 80%-100% within 3 years and clinical recurrence 20%-25% within 2 years. The purpose of this study is to review the strategy of risk stratification and better management of recurrence prevention.

Methodology: Extensive literature search.

Findings: Severity of endoscopic lesions used as predictive marker for future recurrence rates with a scoring system derived from seminal study by Rutgeerts. Risk factors for postoperative recurrence are: Smoking, prior intestinal surgery, absence of prophylactic treatment (EL1), penetrating disease at index surgery, perianal location (EL2), granulomas in resection specimen (EL2) and myenteric plexitis (EL3). Standard of care for preventing recurrence are: Endoscopic monitoring 6 to 12 months after surgery, prophylactic treatment with mesalamine (5-ASA), nitroimidazole antibiotics and thiopurines. Although safe, 5-ASA has high NNT to avoid clinical recurrence (=12) and endoscopic recurrence (=8). Using nitromidazole antibiotics reduced relapse rates, however, twice as many patients had adverse events and the effect is not sustained beyond 12 months. Thiopurines (AZA or MP) have shown variable benefit in reducing relapse rates in patients with postoperative, but with greater serious AEs than 5-ASA. Studies of postoperative treatment with anti-TNF α have significantly reduced endoscopic and surgical recurrence but not clinical recurrence (see figure).

Conclusion & Significance: Results from large recent trials (e.g. POCER, PREVENT, TOPPIC) have redefined frequency of endoscopic recurrence ($\pm 50\%$ at 1 year; $\pm 80\%$ at 2 year) and its implications (clinical recurrence $\pm 25\%$ at 2 year) if untreated. Until more evidence is evaluated, the current standard of care includes: Smoking cessation, colonoscopic assessment within 1st year after resection, individualized prophylaxis for patient-to-patient basis.

Biography

Vito Annese has achieved his Medical Degree at the Catholic University of Rome and subsequently the CCST in Internal Medicine and Gastroenterology at the same University. He also achieved the Master Degree in Medical Sciences at the KUL University of Leuven in Belgium. He has over 30-years of experience in gastroenterology, with specific interest in functional and inflammatory bowel disorders. He has authored about 300 peer reviewed publications mainly in the field of genetic predisposition and clinical trials in IBD. In the last 10-years he has been head of Gastroenterology at the Research Hospital of S. Giovanni Rotondo and at the University Hospital Careggi of Florence and in addition aggregate professor at the University of Foggia and Florence in Italy. Since one year he accepted the position of Consultant Gastroenterologist at the Valiant Clinic and community based physician at the American Hospital at Dubai.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Our method experience and effectiveness using Argon Plasma Coagulator (APC) as a therapy for Gastroesophageal Reflux Disease (GERD)

Julio Murra-Saca

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A variety of endoscopic modalities have been introduced to treat GERD, including radiofrequency energy, suturing, plication and injection therapy. Argon Plasma Coagulation (APC) of the lower esophageal sphincter and gastroesophageal junction represent a new endoscopic therapy for GERD and has been developed by us with performing and observing during almost 15 years. APC is a diathermy based non-contact therapeutic endoscopic modality that may have a lower risk of perforation than other tissue ablation techniques. Our work initiated after observing the improvements of symptoms of GERD in a patient who has suffered for more than 30 years from this disease and also has Barrett esophagus of the long segment in who we performed in two occasions with one month intervals aggressive ablation therapy with APC. After two therapies with APC the patient reported that he has abandoned his treatment with PPI because his symptoms disappeared. After having observed this phenomenon we initiated our protocol of a new therapeutic treatment with APC with deliberated energy from the gastroesophageal junction in circular motion ascending approximately 6 centimeters. Various rings of ablative therapy are formed with APC. This is similar mechanism of the Stretta device that it is speculated that RF energy induces coagulation of the LES and neuronal tissues within the gastroesophageal junction with use of the Stretta device. This procedure also has been demonstrated to be feasible, as well as safe, and is approved by the FDA for treatment of GERD. Setting: Single endoscopy center; study period from October 2003 to June 2018. Our purpose was to assess the long-term safety and effectiveness. The results are as follows: APC Ablation of de Lower third of the esophagus procedure significantly improves GERD symptoms, quality of life and esophageal acid exposure and eliminates the need for antisecretory medication in the majority of patients at 12 months. Most patients have manifested the reduction of the symptoms in 70-90% of the cases and 70%-80% showed heartburn symptom resolution at 3 and 6 months, respectively. Regurgitation symptoms improved 70%-90% at three months. It can be conclusions that the ablative therapy with argon plasma coagulator for gastroesophageal reflux is safe and effective and is associated with symptom reductions in patients with GERD.

Biography

Julio Murra-Saca is the Chief of Gastroenterology at Hospital Centro de Emergencias San Salvador, El Salvador working in private practice in a gastrointestinal endoscopy unit performing diagnostic and therapeutic endoscopy. One of his main skills is the management of gastrointestinal bleeding as well as endoscopic resection of giant polyps of the colon. He has great experience in the therapeutic use of argon plasma coagulation in the management of multiple conditions in gastrointestinal endoscopy. He also performs intra-gastric balloons for obesity with 13 years of experience in this area.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Combination therapy of Cyclosporine and Vedolizumab is effective and safe for severe, steroid resistant ulcerative colitis patients: Prospective study

Dino Tarabar¹, El Jurdi K², Yvellez O², Milenkovic Z¹, Petrovic S¹, Subotic B¹, Tanja P Brocic¹, Brcrevic I¹, Latinovic O³, Jocic T³ and Rubin D T²¹Military Medical Academy, Serbia²University of Chicago Medicine, USA³Clinical Center Vojvodina, Serbia

Background: Vedolizumab is an anti-integrin monoclonal antibody approved for use in moderate to severe Ulcerative Colitis (UC). However, concurrent use of calcineurin inhibitors was not studied in the original clinical trials but has subsequently been described. Here we describe the efficacy and safety of cyclosporine in conjunction with vedolizumab for severe, steroid - resistant UC patients.

Methods: This is a prospective study of 17 UC patients treated with cyclosporine in conjunction with vedolizumab at the Military Medical Academy in Belgrade, Serbia. UC patients, not responding to IV steroids for 3 days were treated with IV cyclosporine at doses of 2-4 mg/kg titrated to goal trough level of 300-400. At day 8 after IV cyclosporine was started (defined as week 0), those who responded were prescribed vedolizumab 300 mg IV. After vedolizumab was administered, cyclosporine was continued orally at double the IV dose and discontinued after 8 weeks of cyclosporine use. Vedolizumab was additionally dosed at 300 mg at weeks 2 and 6, followed by 300 mg IV every 8 weeks. Patients are planned to be followed up to 52 weeks. Demographics and disease information were reviewed. Clinical and endoscopic response and remission were the primary endpoints.

Results: 17 patients (mean age 40 (range 20-67 years)); mean disease duration 4.9±4 years with severe, steroid-resistant UC were treated with cyclosporine. Two patients did not respond to I.V cyclosporine and were referred to surgery. 15 (79%) patients (9/15 male) initially responded to I.V cyclosporine (median cyclosporine dose 200 mg (100-300) IV and 400 mg (200-600) oral. At admission, patients' median Lichtiger score was 12 and Mayo endoscopic subscore was 3. At initial follow-up at week 10, 11 (73%) patients achieved a Mayo subscore of ≤1 (decrease from 3 at admission). Patients' mean Lichtiger score decreased to 5 at week 0, CRP decreased to 15.9, 5.8 and 3.8 mg/L at weeks 0, 2, 6, respectively. At week 26, 14/15 patients were in clinical remission and 11/14 are still in endoscopic remission with Mayo subscore ≤1.

Conclusions: This is the first prospective study of cyclosporine and vedolizumab in steroid-refractory severe UC patients. We demonstrate significant effectiveness and safety of this treatment on week 10 and 26 after vedolizumab was started. Further trials are warranted.

Biography

Dino Tarabar graduated from University of Belgrade, School of Medicine in 1984. Specialized internal medicine in 1995 and currently is a subspecialist gastroenterologist/oncologist. He is a full professor and currently deputy chief of the Clinic of gastroenterology at the Military Medical Academy and also heads the department for the treatment of IBD. He is a member of the European Association for the Treatment of IBD (ECCO), a member of the American Association for the Treatment of IBD patients (CCFA), the Association of American Gastroenterologists (AGAF), the European Association for the Treatment of Malignancies (EORTC), the European Society of Medical Oncologists (ESMO). He has published more than 120 papers in domestic and international journals, 30 of which in journals of leading international significance.

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August 06-07, 2018 Abu Dhabi, UAE

Screening of celiac disease in irritable bowel syndrome by routine endoscopic duodenal biopsy: Review of literature and opinion

Mohan Khadka

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Statement of the Problem: Celiac Disease (CD) screening test in patients with Irritable Bowel Syndrome (IBS) symptoms is recommended by many international society guidelines including American College of Gastroenterology, given the higher global prevalence of CD approximately 4 times higher in IBS than in the general population of <1%. Though, screening of CD by serological test is preferred, duodenal biopsy is the gold standard for the definitive diagnosis of CD. In practice, most IBS patients undergo upper gastrointestinal endoscopy sooner or later for evaluation of high associated conditions like dyspepsia and or Gastroesophageal Reflux Symptoms (GERD). So, taking routine duodenal biopsy to screen CD looks reasonable.

Methodology: Medline, PubMed and EMBASE were searched for the keywords irritable bowel syndrome, celiac disease, routine endoscopic duodenal biopsy (1991 to 2018).

Findings: When the pretest probability of CD is perceived to be low (<5%), serologic study with IgA anti tTG (immunoglobulin A anti tissue transglutaminase) is the initial preferred test in excluding the diagnosis. Patients with a high probability of CD (>5%), regardless of the serology, should undergo an upper endoscopy with small bowel biopsy to confirm the diagnosis of celiac. As per most of the studies, pretest probability of CD in IBS is close to 3%. Different studies have shown that routine endoscopic duodenal biopsy in presumed IBS have diagnostic yield of CD from 2.4 % to 5%. In contrast to 99-100% yield of sero-positivity in classical CD, in atypical CD like IBS, the sero-positivity is only 40 -70%. There is high association of dyspepsia (27-87%) and GERD (42%) in patients with IBS. By doing routine duodenal biopsy, other associations of IBS such as giardiasis, collagenous sprue etc could also be ruled out.

Conclusion: Though pretest probability of CD in IBS may be <5%, it seems logical to perform routine endoscopic duodenal biopsy in patients with IBS to screen for CD as practiced in many centers in USA, Europe and Asia.

Biography

Mohan Khadka has gained close experiences of medical education and state of art training from Nepal, India and China. He was also certified by ECFMG (USA) in 2006 for passing USMLE. In 2009, he got special training of wireless video capsule endoscopy from a pioneer institute Chongqing medical university, China and in 2015 also had opportunity to get advanced level of training from a tertiary referral gastroenterology center at GB Pant Hospital, Delhi, India. In the period of 2011 to 2016, he has attended, chaired and presented in many national and international conferences, seminars and endoscopy workshops. He has published more than half dozen papers in national and international peer reviewed journals and is also reviewer and editor of some international journals. His interest is exploring novice in Irritable bowel syndrome, Celiac disease and Video capsule endoscopy.

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August 06-07, 2018 Abu Dhabi, UAE

In pursuit of complete ERCP: Contrast-assisted cannulation beyond wire guided cannulation

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ERCP is the standard procedure for endoscopic biliary treatment. However the rate to access Bile Duct (BD) has not up to 100% on any facilities, between 92.5 with 98.7% in previous reports. How would we shoot the rest cases? Consider how to improve them. Popular Wire-Guided Cannulation (WGC) would not elucidate unsuccessful cases owing all to endoscopist's skill without key images of cannulation difficulty. On the other hand Contrast-Assisted Cannulation (CAC) provides much information. In practice, there are many anatomical variations of Intra-Ampullary Bifurcations (IAB). A small volume of contrast may provide useful guidance for its variation and angle of IAB, furthermore the presence of Intra-Ampullary Choledochocoele (IAC), which has not reported. IAC is recognized a tiny cyst on midway of BD within ampulla by only CAC, would require refractory pursuit the deformed axis even shown pathway. We report our consecutive data on our facility. We have been consecutively performed ERCP with CAC for all patients. Our strategy was carried out with a small volume contrast medium injection. A selective cannulation to BD was completed by a catheter operation only without Guide Wire (GW) seeking. The success rate to access BD was 97.9% and overall post-ERCP pancreatitis was 1.6%. We consider the difficulty of ERCP would be related with shape of papilla. We also show its variation and classification out of our accumulation. The difficulty on ERCP was morphologically evaluated by anatomical IAB. IAC is only recognized by CAC even GW would not trace the deformed axis. IAC would be one of the factors for difficult ERCP, therefore CAC would be a preferable strategy to identify the presence of IAC. Careful treatment under knowledge of IAB would provide secure and certain ERCP.

Biography

Noriyuki Nishino has his expertise in evaluation and passion in diagnosis and treatment of Gastroenterology, especially pancreatobiliary system with ERCP and diagnosis by Abdominal xerography. He has completed his Graduation from Jichi Medical University in 1987. He is a Director of Gastroenterology Center, Southern TOHOKU Hospital.

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August 06-07, 2018 Abu Dhabi, UAE

Hepatocellular carcinoma: Prognostication beyond size and number

Kaiser Raja

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Hepatocellular Carcinoma (HCC) is one of the main causes of death in cirrhosis. Apart from chronic hepatitis B, hepatitis C and alcoholic cirrhosis, metabolic syndrome associated NASH is emerging as an important risk factor for HCC. Robust radiological diagnostic criteria for HCC have been defined thus obviating the need for liver biopsy in more than 90 percent of cases. While early HCC (small <3 cm) in a patient with child A cirrhosis can be effectively treated by resection or ablation, most patients presenting with advanced HCC have limited treatment options. Prognostication of HCC is extremely important while selecting patients for transplantation so that post-transplant recurrence can be minimized. The Milan criteria and the University College of San Francisco (UCSF) criteria are based on the principle of size and number of tumors, which are regarded as an indirect marker of tumor aggressiveness and biology. Vascular invasion is an important predictor of recurrence and while major vascular invasion is a contraindication to transplant, there is no direct measure of micro-vascular invasion. Although high levels of Alpha-Fetoprotein (AFP) and Des-Gamma-Carboxy-Prothrombin (DCP) have been shown to adversely affect prognosis, the search for a perfect marker that would determine tumor biology remains elusive. Ongoing research is now focusing on tumor biology to select treatment options including candidates for transplant. Tumor biology can be assessed by serum biomarkers, tissue biomarkers, molecular (gene) markers, histological markers and specialized radiological features. Gene expression profiling has allowed stratifying HCCs into several clinically relevant subgroups that were previously unrecognized by conventional methods. Specific gene signatures of aggressiveness, micro-vascular invasion, recurrence and risk of metastases have been developed. HCC-associated micro RNAs have also been assessed as diagnostic and prognostic biomarkers. ¹⁸F-FDG PET/CT has been shown to provide excellent prognostic information. Tumors that are PET avid show poor differentiation, micro-vascular invasion, are associated with higher AFP levels and have a higher risk of recurrence after transplant or resection. ¹⁸F-FDG PET/CT may have a role in identifying patients within Milan or UCSF criteria who may have higher recurrence risk post-transplant and therefore may not be offered transplant as well as identifying patients outside standard criteria who may have a low recurrence risk and therefore may be offered transplant. To conclude, evidence suggests that intrinsic biologic characteristics of the tumor in terms of proliferation and invasiveness lead to very different clinical outcomes. Numerous biomarkers, and imaging with ¹⁸F-FDG PET/CT have been studied that provide additional information for HCC biologic behavior, metastasis and recurrence compared to traditional radiological and histo-pathological features.

Biography

Kaiser Raja is a Senior Consultant Physician in Liver Diseases and Liver Transplantation. He is the Chief Hepatologist for the Integrated Liver Care Team at Aster DM Healthcare Group in India running multi-organ transplant centers at Aster CMI Hospital, Bangalore and at Aster Medcity in Kochi, India. He has completed his post-graduate medical training in Internal Medicine and Gastroenterology from the renowned Postgraduate Institute of Medical Education and Research, Chandigarh India. Following that he has done an Advanced Liver Diseases and Transplant Hepatology Fellowship from the Mount Sinai Medical Center, New York. He has several publications to his credit. His areas of interest are chronic viral hepatitis, autoimmune liver disease, liver cancer and post transplantation care.

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Management of acute variceal bleed by esophageal variceal ligation: A Comparative prospective study between the conventional position and an unconventional position with stratified benefits

Prithvipriyadarshini Shivalingaiah
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Acute variceal bleed is a fatal complication in patients with liver cirrhosis, and it is important to achieve hemostasis at the earliest. Endoscopic variceal ligation is a preferred modality in controlling variceal bleed. The blood pool in esophagus and oozing of blood from varices cause hindrance for variceal ligation leads to failure of therapy. With this background, endoscopic variceal ligation of patients in sitting position was done and results were analyzed. Cirrhotics presenting with hematemesis were included in the study. Amongst them, patients having hypotension and hepatic encephalopathy were excluded. Initial endoscopic assessment was done in left lateral position; patients with isolated gastric variceal and ulcer bleed were further excluded. Amongst 98 acute bleed patients selected, 28 fulfilled the inclusion criteria for the study. They were divided into two groups of age and CTP score matched groups of 14 in each arm. In the first group, during endoscopy, position was shifted from conventional left lateral position to sitting posture and improvement in field of vision was noted as the blood moved to stomach by gravity and band ligation was done. Initial assessment during the study revealed: Better visibility aiding the procedure, no aspiration during the procedure, duration of band ligation was comparable to that of non-bleeders and additional sclerotherapy was not required in any case. In the second group, EVL was done in conventional left lateral position and it was noted that procedure time was delayed and three patients' required additional sclerotherapy and two patients had recurring bleed within 48 hours of procedure. Following the procedure, patients were observed for five days. There was no failure of therapy in the first group, which was analyzed according to Baveno vi consensus. There was one death in each arm. In the unconventional position group, death was due to sepsis and metabolic acidosis causing death and second group, death was renal failure and shock. This study suggests, endoscopic variceal ligation in sitting position, in suitable patients helps in achieving hemostasis early with least complications.

Biography

Prithvipriyadarshini Shivalingaiah is a Medical Gastroenterologist, working as a consultant in Narayana multispeciality Hospital in Mysore, India since 3 years. Having completed MD in internal medicine in the year 2010 and DM-Superspeciality and DNB in Gastroenterology in the year 2015 and 2016 from Bangalore. She is well versed with clinical gastroenterology and Hepatology as well as performs therapeutic endoscopic procedures like endoscopic variceal ligation, sclerotherapy, ERCP, stenting, dilatations of strictures, colonoscopic polypectomies, APC and so on. She has over four publications and presented at CMEs and conferences across India. Presented at Asia pacific Liver conference- APASL 2017 held in China. A good speaker and orator who has given talks in various medical as well as general gatherings, both in rural and urban areas to raise awareness on health issues in India. She has organised and been a part of various charity health camps across rural India.

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El Salvador atlas of Gastrointestinal Video Endoscopy online academic site as a learning resource

Julio Murra-Saca

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Background: El Salvador Atlas of Gastrointestinal Video Endoscopy is an internet based digital video atlas for educational purposes that has been on the web for 18 years with more than 4700 video clips and images. Endoscopy is a visually oriented discipline. Video clips, by virtue of their dynamic nature, provide greater visual detail of gastrointestinal anatomy and pathology than photographic images.

Methods: Endoscopic procedure, endoscopy, enteroscopy, colonoscopy ERCP were digitally captured in real time, edited and correlated with corresponding pathology, radiology and surgery for each completed clip, the final completed clip were rendered in MPEG-1 format and subsequently converted to Real Media for on-demand viewing as streaming video via internet. The user interface is server generated dynamic HTML pages, with relational database system backend.

Conclusion: El Salvador Atlas of Gastrointestinal Video Endoscopy represent internet base, fully digital, educational video atlas of gastroenterology which integrates multiple endoscopic images modalities with relevant surgical, pathological and radiologic data. The substitution of video clips for still images will provide greater educational benefit. El Salvador Atlas of Gastrointestinal Video Endoscopy may represent an educational milestone for the dissemination of knowledge to the practicing physician, trainee and medical students.

Biography

Julio Murra-Saca is the gastroenterologist chief of gastroenterology at Hospital Centro de Emergencias San Salvador, El Salvador working in private practice in a gastrointestinal endoscopy unit performing diagnostic and therapeutic endoscopy. One of his main skills is the management of gastrointestinal bleeding as well as endoscopic resection of giant polyps of the colon. He has great experience in the therapeutic use of argon plasma coagulation in the management of multiple conditions in gastrointestinal endoscopy. He also performs intragastric balloons for obesity with 13 years of experience in this area.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Comparative study between fibroscan and liver biopsy results in chronic HBV patients from south India

Sravan Thumati and A Aravind
Kilpauk Medical College, India

Aim: The study aimed to compare and validate the results of fibroscan versus liver biopsy among chronic HBV patients who are not candidates for treatment according to AASLD Guidelines.

Methods: 54 chronic HBV patients who are having a standard indication for liver biopsy were included. Patients were subjected to liver biopsy and fibroscan study.

Results: The mean age of our patients was 42 years. Study population showed male predominance as the number of males was 40 cases (74.07) while the number of females was 14 (25.29). The mean ALT was 35.01U/L and the mean AST level was 30.89U/L. HBV DNA levels were quite variable with a minimum of <1000 IU/ML and a maximum of 1,01,62,000 IU/ML with a mean of 2,613,52.

Conclusion: Liver stiffness assessment was found to be correlated with liver fibrosis however the results of liver biopsy were not similar to fibroscan results. Most of the case had a fibroscan result less than liver biopsy results by Metavir score. Only cases with Metavir score of F0 coincided with fibroscan results. Liver stiffness measurement could be used as a predictor for liver fibrosis in chronic HBV patients but still liver biopsy may be required to confirm treatment decisions.

Biography

Sravan Thumati is pursuing his Post-graduate from the Department of Medical Gastroenterology Kilpauk medical college Chennai India.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Response to proton pump inhibitor therapy in a racially diverse cohort of pediatric eosinophilic esophagitis

Seema Khan

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Background: Eosinophilic Esophagitis (EoE) is a chronic immunologic disorder characterized by esophageal dysfunction and dense esophageal eosinophilia. The incidence rates are 5.1 and 7 per 100,000 person years in children and adults, respectively. An initial histologic response to proton pump inhibitor has long been viewed as favoring gastroesophageal reflux disease and its use is thus proposed in the diagnostic approach. It is evident from recent literature that PPI therapy has an anti-eosinophil effect, thereby inducing a histologic response independent of GERD status.

Aim: Investigate the response to the initial PPI regimen in children with EoE.

Methods: We performed a retrospective review of data pertaining to children referred to the multidisciplinary EoE clinic at CNMC. We included children with EoE (peak >15 EOS/HPF at any esophageal level) who underwent a histologic reassessment after 8 weeks of PPI (1-3 mg/kg/day) at CNMC. Histologic response was defined as 5-15 EOS/HPF and remission as <5 EOS/HPF.

Results: We reviewed data for 71 children with EoE, age 8 mo-17 yr (6 yr), Caucasian 26 (36.6%) and 43% African Americans (AA) among non-Caucasians. Only 15 children met inclusion criteria comprising of 73% males, 53% non-Caucasians including 33% AA, age range 1-17 year (7.6 year). Histologic remission with minimal symptomatic improvement occurred in only one patient. The pre-PPI and post-PPI therapy peak EOS/HPF were 10-100 (52) and 1-100 (54), p=0.74.

Conclusions: We did not observe PPI therapy as sufficient to alter esophageal histologic status favorably in contrast to adults with EoE. To our knowledge, our Pediatric EoE, is the only uniquely non-Caucasian predominant cohort reported to date. The retrospective nature, variable regimens, and absence of formal GERD investigations are limitations of the study. Extending the analysis to additional patients is expected to provide useful insight into PPI effects in EoE.

Biography

Seema Khan is a pediatric gastroenterologist in Washington, District of Columbia and is affiliated with multiple hospitals in the area, including Children's National Medical Center and MedStar Georgetown University Hospital. She received her medical degree from Aga Khan Medical College and has been in practice for more than 20 years. Dr. Khan accepts several types of health insurance, listed below. She is one of 14 doctors at Children's National Medical Center and one of 14 at MedStar Georgetown University Hospital who specialize in Pediatric Gastroenterology.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

A study of clinical and endoscopic profile of acute corrosive injury of the UGI tract: A single centre study

Ravi Anand, K Caroline Selvi, A Anand, T Rajkumar Solomon, A Aravind, G Ramkumar, R Balamurali, K Muthukumar, Vaishnavipriya, S Kavitha, Umalakshmi Premnath, Dhande Sachin Kashinath, Sravan Thumati, S B Malipatil and S Ragvendra

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Introduction: Corrosive injuries are one of the important public health issues especially in developing countries like India causing a spectrum of complications.

Aim: To review clinical and endoscopic findings of patients with acute corrosive injury and management of these patients.

Methods: In this prospective study, clinical data of 61 patients were collected from July 2016 to July 2017 who came at our centre with corrosive ingestion within 48 hrs. Full clinical examination was done and chest x ray was taken. Patients with no evidence of perforation underwent upper GI endoscopy and initial conservative management was instituted. Corrosive injuries were graded by Zargar's classification.

Results: Out of 61 patients, complete evaluation was possible only in 53 patients. 37 male and 16 female patients were evaluated and mean age was 29 years. Mean time interval of presentation was 17 hours and volume of corrosive ingestion was 20 to 150 ml. Most common corrosive in our study were acids that included hydrochloric acid (n=28), phenyl (n=9), sulphuric acid (n=2), nitric acid (n=2), aqua regia (n=1) along with alkali (n=9) and two cases of kerosene ingestion. Five cases were accidental while 48 cases were of suicidal ingestion. Most common clinical feature in our study were oropharyngeal injuries (n=43), epigastric pain (n=34), sialorrhoea (n=31), vomiting (n=30), odynophagia (n=25) and dysphagia (n=23). 46 patients had esophageal injuries (grade 1=27, 2a=9, 2b=5 and 3=5) while 40 patients had gastric injuries (grade 1=18, 2a=9, 2b=5 and 3=8). Ryle's Tube (RT) insertion was done in six patients with grade 2b and 3 injuries. Patients who came for review after 4 to 8 weeks improved spontaneously with grade 1 and 2a injuries. Five patients with 2b and 3 injuries required feeding jejunostomy initially while all six patients with RT required dilatation after four weeks.

Conclusion: Patients with acute corrosive injury can be assessed reliably and accurately by upper GI endoscopy and proper clinical examination and managed accordingly.

Biography

Ravi Anand is currently pursuing his DM Gastroenterology Degree from a prestigious medical college and hospital from Chennai located in south India. He has completed his MBBS and MD Medicine from Banaras Hindu University. He is interested in field of luminal gastroenterology and various endoscopic procedures. He was working in the gastroenterology department before joining his DM course immediately after passing his MD Medicine and gained his initial training in various endoscopic procedures there. His main aim is to bring the benefit of the best of gastroenterology for the people who are still in need of it for better diagnosis and management of their illness.

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16th International Conference on

GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Eradication of viral hepatitis

K S Somasekhar Rao

Save the Liver Foundation, India

Statement of the Problem: Hepatitis B and hepatitis C are widely prevalent all over the world and Eradication of these viruses is a challenge. Among the challenges in eradicating these chronic hepatitis viruses, most important aspect is to identify the existing pool of patients and treating them. Once the source of infection (positive patients) is identified and controlled (undetectable viral load), eradication of these viruses is a possibility in near future.

Aim: Eradication of chronic viral hepatitis at IEJA.

Methods: Identified a very high prevalent zone for hepatitis C in the state of Telangana, India. Every individual in the village was screened for hepatitis B and hepatitis C. All patients were consulted by a hepatologist and necessary investigations were done. All patients requiring treatment for hepatitis C were started on antivirals, all their family members and others who were found to be negative for the viruses were counseled regarding the modes of transmission and care to be taken. All the patients who were started on treatment were followed up regularly and compliance on drug intake was monitored. All these patients were tested for SVR (Sustained Virological Response) after 6 months (24 weeks) of completion of Treatment. Repeat screening for hepatitis C in the same village for all the individuals after 7 months did not show any new positive HCV cases.

Results: 300 patients were included in the study. 30 patients were found to be cirrhotics at baseline and antivirals (sofosbuvir+daclatasvir) were given for a period of 24 weeks. Patients with serum creatinine more than 3 mg/dl were excluded. Three patients with HCC were identified and were not included in the study. 227 patients who were non-cirrhotics were treated with a combination of sofosbuvir and daclatasvir for a period of 12 weeks. 40 patients had undetectable HCV RNA at baseline and they were not started on antivirals. Out of 257 patients who were started on antivirals 230 patients achieved SVR.

Conclusion: Prevalence of cirrhosis is about 10% in anti HCV positive population. Incidence of HCC is about 1% in anti HCV positive patients. Treatment with a combination of sofosbuvir and daclatasvir achieved SVR in about 90% population in pangenotypic hepatitis C infection. Identifying positive patients in the community who are the source of infection and treating them effectively with an improved awareness among the general public and close contacts of infected patients can decrease the spread of chronic viral hepatitis and help in eradicating these viruses effectively.

Biography

K S Somsekhar Rao is a well-known gastroenterologist and hepatologist in Apollo Hospitals, Hyderabad, India.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Endoscopic management of upper GI bleeding

Mahmoud Hallal

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The worldwide approach to upper GI bleeding is becoming uniform, both medical and endoscopic management. It is evident that in the most of cases high dose PPI should be started to downstage the endoscopic lesion and decrease the need for endoscopic intervention, but should not delay early endoscopy (within 24 h). Endoscopic hemostatic therapy is indicated for pts with high-risk stigmata and no single method of endoscopic thermal coagulative therapy is superior to another. Clips, thermo-coagulation or sclerosant agents should be used in pts with high risk lesions alone or in combination with epinephrine injection. When there is no active bleeding but a red protuberance is seen in the center of an ulcer, most would inject with epinephrine and in addition, use APC, heat probe, or clips. Epinephrine injection alone provides suboptimal efficacy and should be used in combination with another method. IV erythromycin will help but should not delay the decision of urgent endoscopy; when oozing is seen from an ulcer site, injection with epinephrine and or the argon plasma coagulator used, followed by ethanolamine. Other endoscopic modalities can be used including hemospray, rubber band ligations. Patients admitted to the hospital whose GI bleeding requires therapeutic endoscopy, but they do not take a second look on the day after the endoscopic examination unless active bleeding recurs. None of the International Board members would perform any therapeutic measures if melena was the presenting symptom and a clean ulcer base was present in the duodenum. Biopsy specimens for *Helicobacter* are usually taken if hemostasis has been achieved. All skills have a learning curve and we recommend use what you are expert in stopping bleeding. The GI endoscopist should achieve their skills based on workshops and hands-on training to be certified in therapeutic endoscopic management.

Biography

Mahmoud Hallal has completed his MBChB on 1987 from Baghdad University and his Internal Medicine Diploma 1991 and Gastroenterology Diploma 1993 from American University of Beirut. (AUBMC), Post University training in therapeutic Bilio Pancreatic (ERCP) and Invasive endoscopy at CHU de Nice November 1998, MBA Master Of Business Administration, hospital administration 2017 Islamic University Of Lebanon. He is an LSGE (Lebanese society of gastroenterology) Active Member since 1994 and an international ASGE member since 2005 and ESGE member since 2015. He participated as speaker and workshop leader and expert trainer in hands-on endoscopy training in Lebanon and Egypt. Currently he is the Gastroenterology fellowship program coordinator at Zahraa University Hospital affiliated with Beirut Arab University (BAU) from 2011 till now and the Clinical instructor At Lebanese University faculty of medical sciences since 2017 till now.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Acute appendicitis pathway: A systematic review

Haifaa M Malaekah

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Background & Aim: Despite the effectiveness of Clinical Pathways (CP) in reducing healthcare cost and minimizing variability in the management of particular diseases, there are no standardized pathways for common conditions such as appendicitis. This study aimed to determine whether implementation of a pathway for appendicitis leads to improved patient care.

Methods: A systematic review was performed of PUBMED, MEDLINE and Cochrane Library from 1974 to December 2015. The inclusion criteria were human, appendicitis, CP, original article and English language. 37 of the identified studies comprised of 16,006 participants met selection criteria.

Results: There was a clear definition of the appendicitis pathway within 30 articles. Appendicitis was diagnosed on the basis of clinical and laboratory findings. 43% of the studies added radiological investigations. There was a clear definition for discharge criteria in 16/37 studies. 10 studies reported time of follow-up for their patients (5-28 days). Operative time was the most commonly used outcome measure 25/37 (67.5 %). Nine articles reported the Length of Stay (LOS) for non-complicated appendicitis, mean=1.3 days and 8 articles for complicated appendicitis, mean=6.26 days. The majority of studies investigated the accuracy of the pathway in the diagnosis of appendicitis by looking at the incidence of a normal appendix, mean=9.15%. Four articles documented the mean cost of patient care, mean=\$4,874.14.

Conclusion: There is not a standardized definition of appendicitis pathway components within the medical literature. These studies suggested that an appendicitis pathway decreases the duration of hospitalization and prove useful as a means to minimize costs.

Biography

Haifaa M Malaekah is a General surgery and Colorectal Consultant and Member of Saudi Society for Colon and Rectal Surgery and Manager of Postgraduate Professional Development Program at simulation center. He is a certified healthcare simulation educator. Currently, he is working at King Abdullah bin Abdulaziz University Hospital at surgical Department. In addition, he has obtained a Master's degree in Epidemiology and Medical Statistics. He has accomplished 2 years of Fellowship in Colorectal Surgery at 2015, University de Montreal and 1 year Fellowship in Surgical Simulation, McGill University, Canada. He continued working in McGill University as Postdoctoral Fellow for 6 months. He has an interest in medical education, simulation and researches.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Pre malignant conditions of colonic carcinoma

Deepak Ghuliani

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Colorectal Cancer (CRC), commonest gastrointestinal malignancy develops from the progression of acquired or hereditary premalignant lesions. 75% of colorectal cancers are “sporadic while a potential genetic influence is identified in the remaining 25% of patients. The tumor results from complex interactions between several risk factors (environmental, dietary, familial and hereditary) which become relevant during the different stages of colorectal carcinogenesis. The Chromosomal Instability (CIN)/Loss of Heterozygosity (LOH) pathway and the Microsatellite Instability (MIN)/Replication Error (RER) pathway are two well-described genetic pathways leading to the development of colorectal adenocarcinoma. Most, if not all colonic cancers develop from a precursor polyp. The most common neoplastic polyp with malignant potential is the adenoma. It follows the adenoma-carcinoma sequence where inactivation of APC gene sets the stage for accumulation of genetic damage leading to a malignancy. Carcinomas are found in 0% to 4% adenomas. Histologically divided as tubular, villous and tubulovillous- the size and histology of adenomas are independent risk factors. Serrated polyps - another type of neoplastic polyp are mixed hyperplastic and adenomatous polyps. The sessile and traditional serrated types are the definite precursors for colonic cancers. Adenomas, may occur sporadically or as part of one of the hereditary syndromes like Familial Adenomatous Polyposis (FAP), Attenuated FAP, Gardner's and Turcot's syndrome. FAP is the commonest adenomatous polyposis syndrome with 100 to 1000 polyps all over the colon, more in the left and associated with 1% of colonic cancers. Besides, several hamartomatous polyposis syndromes like Peutz-Jeghers syndrome and Juvenile polyposis syndrome have markedly increased risk of colonic cancer with development of extra-colonic manifestations, both malignant and non-malignant. Hereditary Non Polyposis Colonic Cancer (HNPCC) is the most common familial colorectal syndrome associated with 2-3% of colorectal cancers. The associated colonic cancer occurs at an early age (44 years), 70% are right sided with a 40% risk of synchronous and metachronous cancers. Other premalignant conditions include inflammatory bowel diseases: Ulcerative colitis and Crohn's disease where the risk is directly proportional to extent and duration of disease. Thus early identification of these conditions not only provides the opportunity to either prevent the progression to cancer or diagnose cancer at an early curable stage but also allows for appropriate surveillance and management, which varies considerably between syndromes. Clinical testing for germline mutations should occur in the setting of appropriate genetic counseling and offer predictive testing for family members.

Biography

Deepak Ghuliani is currently working as Professor of Surgery at Maulana Azad Medical College, New Delhi has a special interest in Gastrointestinal and Endocrine surgery. He is working as a General Surgeon, he has a vast experience in all types of gastrointestinal and hepatobiliary cases especially the GI Oncology. Besides clinical practice he has a passion for teaching and all types of academic activities. He has several publications in National and International journals. He is working as Professor of Surgery not only is he conducting research and teaching undergraduate and postgraduate medical students but also actively involved in conferences, CME's, skills workshops, updates in the role of speaker, chairperson, judge, trainer and also a quiz master.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Colon polypectomy and endoscopic mucosal resection

Shahram Agah

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About 70%–80% of colorectal neoplasia arises from conventional adenomatous polyps. Polypectomy reduced the risk of colorectal cancer by the order of 75%–90%. 80% to 90% of polyps are smaller than 10 mm. Morphological description (considering Paris classification), Size estimation (smaller or larger than 10 mm), Relation to the surrounding mucosa: (e.g. Saddle distribution over a fold, or an invasive lesion. Safe polypectomy implies the ability to resect and completely remove a polyp while achieving hemostasis and maintaining the integrity of the colonic wall. Polyps of ≤ 6 mm can be safely removed by cold snaring. Electrocoagulation with a blend or cutting setting should be used for polyps >10 mm. The different snare is using for the polypectomy. Try to put the polyp at 5 to 6 o'clock position at the time of resection. Small, flat sessile polyps, pedunculated polyps with very large pedicles, large flat sessile lesions or laterally spreading tumors are challenging polyps. For the first one, the cold snare is the safest method. For the second one, post-polypectomy hemorrhage is the most problems which can be prevented with endoloop or clip. For laterally spreading tumor or large sessile lesion, EMR is recommended. Injection is recommended in lesion >10 mm in the right, >15 mm in the left and in both parts if a lesion is hidden behind a fold. With moderate expertise, EMR of the lesions occupies more than one-third of the circumference of the colonic wall or maximally crosses over two haustral folds. Submucosal sequential injection and piecemeal resection after 1 to 2 ml saline or gelfusion. Resect most inaccessible first. Consider removal of some normal tissues. Consider snare tip soft coagulation of removed tissues rim for reduction of recurrence.

Biography

Shahram Agah is the Director of Endoscopy ward and Colorectal Research Center at Rasoule-Akram Hospital, Iran University of Medical Sciences, Tehran, Iran, where he works as a professor in the field of Gastroenterology and Hepatology. His basic education and professional training have been in Iran, however, he attended at Chemnitz hospital, Germany in 2001 and Rush University, Chicago, USA in 2017 for better experience in therapeutic endoscopy and Endosonography. He has traveled to Australia to obtain more experience in advanced endoscopy (EMR and ESD) and some collaborative researches. He is the principle investigator on several clinical trials in gastrointestinal disorder.

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Direct acting antivirals and hepatocellular carcinoma correlations

M A Ezzel Arab
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Hepatocellular Carcinoma (HCC) is increasing worldwide and particularly in Egypt, where the prevalence of hepatitis C viral (HCV) infection, a well-established HCC risk factor, is the highest in the world. Direct-acting antivirals (DAAs) have completely changed the panorama of hepatitis C due to their high efficacy and optimal safety profile. The impact of DAA-based treatment on the incidence of HCC in patients with cirrhosis and particularly on the incidence of HCC recurrence after successful curative treatment has emerged as a controversial issue with potential clinical implications. As Egypt achieved the highest number (>1.5 million) of treated patients by DAAs globally up till now, it is so important to evaluate its situation in this issue. The talk will highlight on the following items: Discrepancy regarding the occurrence and recurrence of HCC, highlight on some Egyptian studies and possible factors contributing to increased HCC incidence/recurrence by DAAs.

Biography

M A Ezzel Arab is a Professor of Internal Medicine and Hepatology. He is the Founder of Intervention and Hepatoma Unit at the National Hepatology and Tropical Medicine Research Institute (NHTMRI) since 2007. He is a member of the steering committee which put the Egyptian guidelines for HCC (2011) which was sponsored by the Egyptian Society of Liver Cancer (ESLC).

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GASTROENTEROLOGY AND DIGESTIVE DISORDERS

August 06-07, 2018 Abu Dhabi, UAE

Transcriptional Regulation of Bile Acid Metabolism and Microsurgery

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Circadian control of nutrient availability is critical to efficiently meet the energetic demands of an organism. Production of bile acids (BA), which facilitate digestion and absorption of nutrients, is a major regulator of this process. Here we identify a KLF15-Fgf15 signaling axis that regulates circadian BA production. Systemic Klf15 deficiency disrupted circadian expression of key BA synthetic enzymes, tissue BA levels and triglyceride/cholesterol absorption. Studies in liverspecific Klf15-knockout mice suggested a non-hepatic basis for regulation of BA production. Ileal Fgf15 is a potent inhibitor of BA synthesis. Using a combination of biochemical, molecular and functional assays (including ileectomy and bile duct catheterization), we identify KLF15 as the first endogenous negative regulator of circadian Fgf15 expression. Elucidation of this novel pathway controlling circadian BA production has important implications for physiologic control of nutrient availability and metabolic homeostasis. Surgery model like intestinal resection is a common therapeutic approach for human diseases such as obesity, inflammatory bowel disease, Crohn's disease, and colon cancer that often results in severe short bowel syndrome-like adverse effects including bile acid diarrhea, dehydration, electrolyte disturbances, and nutrient malabsorption. We introduce a murine ileal resection model, termed ileectomy, to evaluate tissue communication and the maintenance of systemic homeostasis. Bile is the important cycling fluid in our body composed of multiple components critical for many functions. Here, we successfully established a murine bile duct catheterization (MBDC) model to collect the pure bile continuously from mice under the conscious status. These two novel microsurgery models may provide invaluable platforms for various physio-pathological studies such as ileal regulation of systemic metabolism and diseases, lipid and drug metabolism as well as the diagnosis and prognosis of human diseases like pancreatic and biliary tract cancers.

Biography

I am currently a Senior Research Associate at Case Western Reserve University in Cleveland, Ohio in the US. I will join as a faculty member at the School of Animal Science at Anhui Agricultural University in Hefei, Anhui in China this October. I have been engaged in the metabolic biology for thirteen years. The studies broadly cover the metabolism of endogenous metabolites (e.g., bile acids, steroids, fat, ketone body, and glucose) to exogenous compounds (e.g., drugs). The studies have been mostly focusing on the transcriptional regulation of metabolism by various transcription factors from previously nuclear receptors to currently developmental transcription factors. In the past years, I have been dedicating to the study of developmental transcription factor Kruppel-like factor (KLF) family and developed the novel critical fields of transcriptional regulation of endo- and xenobiotic metabolism under physiological and chemical or surgery induced disease conditions.

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