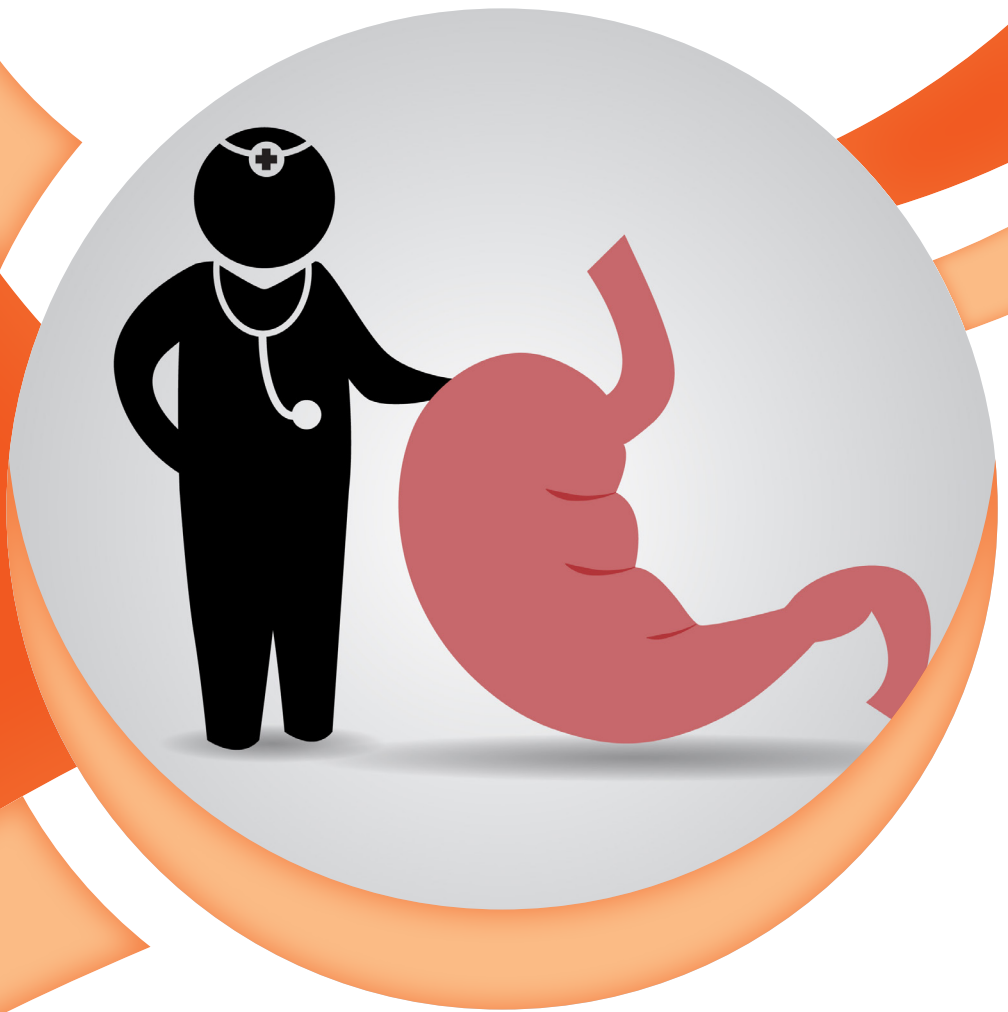




14th Annual Congress on

Gastroenterology & Hepatology

August 06-07, 2018 Osaka, Japan

Scientific Tracks & Abstracts (Day 1)

14th Annual Congress on

GASTROENTEROLOGY & HEPATOLOGY

August 06-07, 2018 Osaka, Japan

Hepatocarcinoma in Guatemala functional three phase CT as diagnosis tool

Luis Fernando Sandoval Garcia, Yolanda Patricia Tolaque Aldana, Manuel Antonio Gatica and Jorge Luis Ranero
Instituto Guatemalteco de Seguridad Social, Guatemala

Guatemala has the highest incidence and mortality of Hepatocarcinoma (HCC) in Latin America and the Caribbean. HCC is associated with chronic liver disease and cirrhosis regardless of the etiology. Only about 10% of HCCs develop in non-cirrhotic livers. HCC can be diagnosed in cirrhotic patients non-invasively based on radiologic findings. Biopsy is only performed when there is a low probability of HCC (doesn't have cirrhosis, chronic hepatitis B nor current or prior hepatitis C). IGSS previous data base have showed more than expected HCC in non-cirrhotic (71%), so we must evaluate our diagnostic protocol with the use of functional three-phase CT. All the liver masses seen by functional three-phase CT were included and compared with the pathology result during 2015-2017 in IGSS. Statistical analysis was performed with PSPP 2007. Categorical variables were presented with frequency and percentages and analyzed by chi squared of homogeneity. Normality was tested with Kolmogorov-Smirnov. Numerical data were evaluated with t-student of independent samples. At relational level a bivariate study was made, then elevated to multivariate level. NPV and PPV were calculated. Total of 76 liver masses evaluated by functional three phase CT were analyzed with 53.85% of HCC confirmed by biopsy; 84% of HCC diagnosis were non-cirrhotic livers. Taking all the samples, our functional CT has a PPV of 0.54 and NPV of 0.69 for HCC diagnosis. After stratification, in cirrhotic samples a PPV of 0.25 and NPV of 0.83, vs. non-cirrhotic a PPV of 0.67 and NPV of 0.62 were obtained. These findings are opposite to the global epidemiology, our main HCC source is the non-cirrhotic livers and that is why we have different experiences in functional imaging.

Biography

Luis Fernando Sandoval Garcia has graduated in General Medicine from Universidad de San Carlos de Guatemala with a Master's degree and Chief of Residents in Internal Medicine at IGSS. He works as an Internal Medicine Attending Physician in the same institute and as Professor in Universidad Francisco Marroquin. Locally he has published researches about gastric cancer, esophageal varices, cirrhosis and HCC. He has showed the first epidemiological formal evidence of the non-cirrhotic HCC at IGSS, Guatemala.

lufesandoval@ufm.edu

14th Annual Congress on

GASTROENTEROLOGY & HEPATOLOGY

August 06-07, 2018 Osaka, Japan

Ammonia level may not be associated with the severity of hepatic encephalopathy: An extensive literature review**Eyad M O E Gadour**

University Hospital of South Manchester NHS Foundation Trust, UK

This literature provides a review regarding the value of checking ammonia level in hepatic Encephalopathy. The research examines the prognosis of Ammonia level in the blood, diagnosis and management of hepatic encephalopathy. The major clinical characteristics of diagnosis of hepatic encephalopathy are depressed consciousness level, intellectual impairment and personality changes. During diagnosis, it is essential to detect signs suggesting hepatic encephalopathy among the patients suffering from liver disease and there is no clear indication of other causes to brain dysfunction. Thus, realization of precipitating factors indicated above supports hepatic encephalopathy diagnosis. The prognosis depends on the grade of liver failure, time of delivering effective treatment particularly precipitating factors and comorbidity. The progress of hepatic encephalopathy among patients with cirrhosis is correlated with a worse prediction and might cause frequent and elevated relapses. The patients with obvious hepatic encephalopathy in the hospitals have a 3.9 risk of increased mortality. Approximately 70% of having cirrhosis exhibit restrained symptoms of hepatic encephalopathy. These symptoms are likely to weaken patients. Obvious hepatic encephalopathy manifests in patients suffering from cirrhosis, and the approximate infection rate is 30 to 45%. About 25 to 53% port systemic shunt surgery patients exhibit the condition. The suitable management practices entail early diagnoses, aggressive identification of the precipitating factors and efforts to reduce severity. Evasion of some sedative drugs has been proposed as a key management practice. The main approaches suggested in include: (1) Checking the level of arterial ammonia during first evaluations in patients hospitalized due to impaired mental function and or cirrhosis. In stable outpatients, ammonia levels are low. (2) Correcting hepatic encephalopathy precipitants including constipation, gastrointestinal bleeding, metabolic disturbances and hypovolemia. (3) Providing prophylactic endotracheal intubation to patients with grade 3 or grade 4 (severe encephalopathy) and have aspiration risks in the Intensive Care Unit (ICU). Lactulose and Rifaximin use is useful but no superiority and can both be used if needed. Administration of low-protein diets in cirrhosis patients resulted in deteriorating of established protein-energy malnutrition. Thus, protein restriction is likely to help some patients with immediate effect after episodic hepatic encephalopathy. Certainly, malnutrition is regarded as a serious clinical problem compared to hepatic encephalopathy among the patients. Blood ammonia mainly comes about due to the breakdown of the unabsorbed dietary protein by bacteria in the intestines. Among the hepatic encephalopathy, the levels of ammonia in the brain are higher compared to blood levels. High levels of ammonia in the blood may occur because of gastrointestinal bleeding, acute liver failure and chronic liver disease. The major reasons for testing ammonia levels in hepatic encephalopathy for patient who is presenting for the first time include: Checking for success of treatment options, checking for liver condition following severe symptoms like excessive sleepiness and confusion, identifying disorders likely to cause brain damage, help in predicting outcomes from diagnoses carried out prognosis of hepatic encephalopathy, however, for patients who are known to have hepatic encephalopathy, in terms of recurrent admissions or previous diagnosis, checking ammonia is not routinely recommended and carrying out the psychometric tests may be more useful.

Biography

Eyad M O E Gadour has an MRCP in Gastroenterology Spr from University Hospital of South Manchester NHS Foundation Trust in UK. He is currently working in University Hospital of South Manchester NHS Foundation Trust, UK.

eyadgadour@doctors.org.uk

14th Annual Congress on

GASTROENTEROLOGY & HEPATOLOGY

August 06-07, 2018 Osaka, Japan

Hepatocarcinoma in Guatemala contrasting global epidemiology

Luis Fernando Sandoval Garcia and Manuel Antonio Gatica
Instituto Guatemalteco de Seguridad Social, Guatemala

Guatemala has the highest incidence and mortality of Hepatocarcinoma (HCC) in Latin America and the Caribbean in both sexes. This liver neoplasm is the 7th cause of cancer in Central America and the 2nd cause of incidence and cancer mortality in Guatemala. There are many risk factors already identified in the indisputable, first place is cirrhosis, then HBV (chronic and carrier), HCV, alcoholism, NAFLD, etc. Only about 10% of HCCs develop in non-cirrhotic livers. In every day medical practice, we have seen an increase in non-cirrhosis HCC with no other traditional risk factors. It woke up our curiosity and interest to characterize our hepatic cancer. It is an observational, retrospective and analytical study. All HCC attended at IGSS in 2015-2016 were analyzed, researching for epidemiological data, focusing in differences between cirrhotic vs. non-cirrhotic patients. Statistical analysis was performed with PSPP 2007. Categorical variables were presented with frequency and percentages and analyzed by chi squared of homogeneity. Normality was tested with Kolmogorov-Smirnov test. Numerical data were evaluated with t-student of independent samples. At relational level a bivariate study was made, then elevated to multivariate level. Total of 53 HCC cases were found, 15 cirrhotic and 38 non-cirrhotic (71.69%). Comparing both groups, there is no statistical difference between age, BMI, sex, family history of cancer, alcoholism, tobacco, diabetes mellitus, obesity, HBV, HCV, AFP, mass diameter, nor treatment (surgery, TACE, radiofrequency and sorafenib). There is difference in jaundice, ascites and encephalopathy, possibly due the same cirrhosis. It should be emphasized the importance of the high number of HCC in apparently healthy livers, contrasting global epidemiology. Staring with this new revealing knowledge we must analyze our medical approach to diagnose and manage HCC in Guatemala and look for our non-traditional risk factors.

Biography

Luis Fernando Sandoval Garcia has graduated in General Medicine from Universidad de San Carlos de Guatemala with a Master's degree and Chief of Residents in Internal Medicine at IGSS. He works as an Internal Medicine Attending Physician in the same institute and as Professor in Universidad Francisco Marroquin. Locally he has published researches about gastric cancer, esophageal varices, cirrhosis and HCC. He has showed the first epidemiological formal evidence of the non-cirrhotic HCC at IGSS, Guatemala.

lufesandoval@ufm.edu

Notes:

14th Annual Congress on

GASTROENTEROLOGY & HEPATOLOGY

August 06-07, 2018 Osaka, Japan

Maintaining remission in patients with Inflammatory Bowel Disease (IBD) is well associated with good control of blood glucose level in different Montreal classes of IBD: A retrospective study of 160 IBD patients in a large gastroenterology center in UK**Eyad M O E Gadour**

University Hospital of South Manchester NHS Foundation Trust, UK

Introduction: Inflammatory Bowel Diseases (IBD) are a group of chronic diseases of the bowels which have unknown etiology. With studies having established that there is a link between diabetes and IBD, this study sought to investigate if there was any relation between blood glucose level (glycemic changes) and remission in patients with IBD. This study examined a number of factors such as the blood glucose levels of the patients and histology among others. The experimental phase of this study divided the participants into three as described in the study sampling including a control group.

Aim: We investigated if there is any relation between blood glucose level and remission in patient with IBD. The hypothesis is glucose status is abnormal in active inactive IBD.

Methodology: A cross-sectional study determines exposure and outcome simultaneously for every subject. The studies have been regarded as the most appropriate for screening hypothesis because they require a comparatively shorter time commitment as well as fewer resources to undertake. The total numbers of sample employed in this study was 160. The study participants were classified into three groups. The first group included the patients with IBD in remission while the second group comprised of the patients who are experiencing flare up. The third group comprised of normal subjects who were equally described as the control group. The inclusion criteria for the participants in this study included age that encompassed 16-90 year-old, the medical condition of the patient where the ones included were known to have IBD and the patients under gastroenterology team at University Hospital of South Manchester. The exclusion criterion was pregnancy. The relationship between study variables was equally examined using the Chi-Square test, and independent T test. Study hypothesis was examined using One Way Anova Test. Regression analysis was also used to identify predictors of IBD. Significance was considered at alpha level <0.05.

Results: Total number of participants was 160. 57% of 91 participants were female (57%), 69 participants were male (43%). Around 68% were aged 40 years and above while 32% were below 40 years of age. The Montreal classification type A2L1B1 (8.1%) was lower compared to 16% of E1S0. There are no significant statistical differences seen in the other disease types. The other Montreal classification category A2L2B2 [16%] equally had a high percentage in diabetes patient but found to have no statistical difference between other Montreal classifications. A1L1B1 Montreal classification category participants have the least relationship with diabetic patients (0.6%).

Conclusion: In conclusion, the principal aim of this study is to monitor the glycemic status of IBD patients during the remission and flare-up. The chi-square of age and sex indicated a variance of 1.55 and $p < 0.05$. This shows that there is no significant difference between age and sex hence most people are affected by IBD. This thus rejects the null hypothesis and accepts alternative hypothesis that states that there is a relationship between glycemic status of IBD patients during the remission and flare-up.

Biography

Eyad M O E Gadour has an MRCP in Gastroenterology Spr from University Hospital of South Manchester NHS Foundation Trust in UK. He is currently working in University Hospital of South Manchester NHS Foundation Trust, UK.

Notes:

eyadgadour@doctors.org.uk



14th Annual Congress on

Gastroenterology & Hepatology

August 06-07, 2018 Osaka, Japan

Workshop

Day 1

14th Annual Congress on

GASTROENTEROLOGY & HEPATOLOGY

August 06-07, 2018 Osaka, Japan

Acute brainstem syndrome secondary to malnutrition from functional dyspepsia

Amit Sen¹, Kirti Kiran Nune² and Mohandas Dhanoop³¹St Marys Hospital, UK²Maidstone Hospital, UK³Isle of Wight NHS Trust Hospital, UK

Brain stem syndrome is a condition commonly characterized by limb weakness, ophthalmoplegia and gait disturbances. The common causes of brain stem syndrome are ischemia, neoplasia, demyelination, infection and hamartoma type lesions in the brain. Imaging ideally with an MRI scan is usually diagnostic in most cases. CSF (Cerebrospinal Fluid) study helps in identifying the cause in most cases. A 42 years old Caucasian lady presented with non-specific symptoms like lethargy and malaise was off food for a couple of months and had lost a considerable amount of weight (4 stones=25.4 kg). She was admitted to the hospital with nausea and vomiting for few weeks and complained of a lump in her throat. Gastroscopy was unremarkable. She also complained of sudden onset of double vision for the last few days and examination showed vertical Nystagmus. She also complained of unusual sensation in her feet and soreness in the bottom of her feet when she stood up. There was no obvious limb ataxia, absent lower limb tendon jerks but flex or plantars and intact objective peripheral senses. Gait was unsteady while walking with eyes open but was better with eyes closed. The patient was lucid the whole time. During the stay in the hospital the patient developed oscillopsia. She underwent an MRI scan which was unremarkable. She was investigated for autoimmune cause including GQ1b for Miller Fischer syndrome and paraneoplastic screen to investigate the weight loss. Lumbar puncture which was performed which showed protein of 0.69 grams/liter and rest of the values are normal. She was transferred to a tertiary neurology center. Based on her clinical examination finding and MRI report she was diagnosed with brain stem syndrome secondary to malnutrition due to functional dyspepsia. She was seen by the dieticians and Nasogastric feed was started.

Biography

Amit Sen is working as a Consultant Physician in Acute and Adult General Medicine at St Marys Hospital, UK. He has graduated from Calcutta University in India 1998 and had further Post-graduate training in Medicine in India and then moved to UK in 2002. He had also received Post-graduate training in Medicine at Liverpool and London. He is attached with National Health Service for the last 16 years and had training in different branches of medicine including cardiology, gastroenterology. He has done various clinical audits and was the Principal Investigator in IST3 Trial (International Stroke Thrombolysis Trial), Clots trial, TARDIS trial. He has interest in teaching medical undergraduate students and he is also a Clinical Supervisor for junior doctors in the current hospital.

Kirti Kiran Nune has graduated from India in 2014. Since then he has been working in the NHS. He has experience as a Junior Doctor in emergency medicine, cardiology, gastroenterology and diabetes and endocrine in Tunbridge Wells NHS Trust, Southampton General Hospital and St Mary's Hospital Isle of Wight. He has undertaken audits in emergency medicine, cardiology and gastroenterology.

Senamit@doctors.net.uk
kirtikiran@gmail.com

Notes:



14th Annual Congress on

Gastroenterology & Hepatology

August 06-07, 2018 Osaka, Japan

Video Presentation **Day 1**

14th Annual Congress on

GASTROENTEROLOGY & HEPATOLOGY

August 06-07, 2018 Osaka, Japan

The management of portal hypertension and esophageal varices

Antonio Iannetti

Sapienza University of Rome, Italy

The main cause of portal hypertension and of the formation of esophago-gastric varices is cirrhosis of the liver. The prevalence of cirrhosis has been estimated at around 0.15% in the United States, with data that are substantially similar in Europe, with even higher numbers in most African and Asian countries (where chronic viral hepatitis B or C are common). Another cause of portal hypertension is schistosomiasis, affecting 200 million people worldwide. Right heart failure, pericarditis, Budd-Chiari syndrome, inferior vena cava thrombosis, extra-hepatic tumors (biliary tract, pancreas, stomach, retroperitoneum) cause portal hypertension. From the point of view of the Endoscopist Gastroenterologist, the main complication of this syndrome is digestive hemorrhage, which is also the main cause of death of the cirrhotic patient and of the patient with portal hypertension. In this presentation, the methods to diagnose this disease are reported with reference to the calculation of the risk of bleeding and the therapeutic techniques of prophylaxis and therapy of the acute event.

Biography

Antonio Iannetti has received his Degree in Medicine and Surgery and Specialty in Gastroenterology and Internal Medicine from the University of Rome and University of Los Angeles, USA, respectively. His research interests are on endoscopic sclerosis of esophageal varices and retrograde cholangiopancreatography-endoscopically. He is also the Head of the Digestive Endoscopy Service of the University Hospital Umberto I in Rome. Presently, he is the Professor of Endoscopy and Digestive System Diseases at the Faculty of Medicine, Sapienza University of Rome. He is also an Expert in the Ministry of Health for Gastroenterology.

antonio@iannetti.it

Notes: