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Research Article **Published Date:-2019-12-05 00:00:00**

Aggressive hydration in early resuscitation phase does not provide mortality benefit in acute pancreatitis

Introduction: Fluid management is the cornerstone of treatment for acute pancreatitis (AP), but the proper rate and volume is still controversial. We aim to evaluate the role of aggressive hydration in AP patients.

Methods: We retrospectively reviewed and analyzed 279 hospitalized patients of AP. Severity was determined by the Revised Atlanta classification; validated clinical scores were also calculated based on clinical information upon presentation. We extracted amount of fluid received by at 6, 12, 24 and 48 hours after presentation. Aggressive hydration was defined as amount higher than 10 ml/kg bolus followed by infusion at 1.5 ml/kg/h. After direct comparison between aggressive versus non-aggressive hydration groups, propensity-score match was performed to control severity, APACHE II and BISAP score. Post-match comparison as well as a subgroup comparison were conducted.

Results: At 24 hours, 125 (44.8%) patients received aggressive hydration averaged at 5.1 L (2-18 L), while 154 (55.2%) patients received non-aggressive hydration averaged at 2.5 L. Post-match comparison showed that aggressive hydration group had longer hospital stay (MAP: 5.3 vs 4.5, p = 0.145, MSAP/SAP: 8.3 vs 4.8 d, p = 0.007), and higher rate of intensive care unit admission (mild: 12.9% vs 4.4%, p = 0.042, moderately severe or severe: 36.8% vs 3.1%, p = 0.001), while showed no difference in rate of mortality or re-admission by 1 year. In patients who presented without organ failure, aggressive hydration did not change the rate of development of organ failure (14.1% vs 12.5%, p = 0.731), but the aggressive hydration group had a trend towards longer hospital stay (5.5 vs 4.6 d, p = 0.083) and higher rate of MICU admission (12.1% vs 4.8%, p = 0.051)

Research Article **Published Date:-2019-11-27 00:00:00**

Gaucher’s disease and liver involvement: A review and our experience

Background: This article reviews current knowledge of Gaucher’s disease (GD) and liver involvement and reports our experience: how many patients with chronic liver disease of unknown origin could be affected by Gaucher’s disease.

Patients and methods: Over 24 months, we tested 75 sine causa chronic liver disease patients (30 women and 45 men, mean age 55 years, range 15 to 77).

Results: None of the 75 patients was affected by Gaucher’s disease.

Conclusion: We believe that the chronic liver disease patient is unlikely to be affected by Gaucher’s disease. Probably this disease is to be found in cases of coexistence of hepatic disease and other symptoms of Gaucher’s disease (bone, neurological, bone marrow involvement).

Research Article **Published Date:-2019-11-13 00:00:00**

Evaluation of outcomes of 8-week therapy with ledipasvir/sofosbuvir or glecaprevir/pibrentasvir in veterans with hepatitis C infection

Hepatitis C Virus (HCV) infection is usually treated with direct acting antivirals (DAAs) for 12 weeks. In treatment naive patients with genotype (GT) 1 infection without cirrhosis and baseline viral load < 6 million, 8 weeks of Ledipasvir/Sofosbuvir (LDV/SOF) is an option. Eight weeks with Glecaprevir/Pibrentasvir (GLE/PIB) is an option for patients with GT 1 through 6 without cirrhosis. Our objective was to evaluate achievement of Sustained Virologic Response (SVR) after 8 weeks of LDV/SOF or GLE/PIB in our HCV-infected veterans. Patients with HCV infection that received GLE/PIB or LDV/SOF for a planned 8 weeks of therapy in the past four years were reviewed (January 2015-September 2018). Treatment outcomes were evaluated through medical record review.

Two hundred sixty-five veterans were initiated on 8 weeks of therapy with either GLE/PIB or LDV/SOF. Of these, 231 (87%) were initiated on 8 weeks of LDV/SOF and 34 (13%) were initiated on 8 weeks of GLE/PIB. The majority of patients had GT 1 (93%) infection. One hundred and ninety-five veterans who completed 8 weeks of LDV/SOF and 30 veterans on GLE/PIB had follow-up viral loads. The overall SVR was 95%. Treatment with GLE/PIB resulted in a higher SVR rate (100%) compared to LDV/SOF (95%). Elderly patients had similar SVR rates. Treatment with 8 weeks of DAA is effective in our veteran population and showed an SVR rate similar to literature reports. The SVR for patients treated with 8 weeks LDV/SOF was slightly lower than the SVR for GLE/PIB; however, the GLE/PIB population was smaller

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Research Article **Published Date:-2019-09-20 00:00:00**

Addition of Simvastatin to Carvedilol and Endoscopic Variceal Ligation improves rebleeding and survival in patients with Child-Pugh A and B class but not in Child Pugh C class

Background: Even with current standard treatment after variceal bleeding which includes combination of nonselective b-blockers and repeated endoscopic variceal ligation, the risk of rebleeding and mortality are high. Statins exhibit an antifibrotic effect and improves HVPG. We evaluated whether addition of simvastatin to carvedilol plus EVL therapy reduces variceal rebleeds or death in patients with cirrhosis.

Method: Patients with a variceal bleed 5 to 10 days before were randomly assigned to groups A [carvedilol (n = 69)] or group B [carvedilol (maximum dose - 12.5mg), and simvastatin (40mg/day) (n = 65)]. Primary end points were variceal rebleeding or death. Secondary end points were new complications of portal hypertension and serious adverse effects of drugs.

Results: During a mean follow-up of 49.05 ± 25.74 weeks, composite end point i.e. rebleeding or death developed in 23 patients (33.3%) in group A and 12 patients (18.5%) in group B [HR for simvastatin = 0.512; 95% CI: 0.254 – 1.030; p = 0.06]. In subgroup analysis by excluding patients of Child C class, 18 patients (34.6%) in group A and 7 patients (13.6%) in group B developed composite end point [HR for simvastatin = 0.369; 95% CI: 0.154 – 0.887; p = 0.026]. 17.4% and 15.4% patients in group A and B developed additional secondary complication [HR = 0.86; 95% CI: 0.345-2.161; p = 0.75). No simvastatin induced significant adverse effects were found.

Conclusion: Addition of simvastatin to carvedilol and EVL may reduce the rebleeding and death in patients with less advance liver disease.

Research Article **Published Date:-2019-07-08 00:00:00**

Endoscopic treatment of pancreatic diseases via Duodenal Minor Papilla: 135 cases treated by Sphincterotomy, Endoscopic Pancreatic Duct Balloon Dilation (EPDBD), and Pancreatic Stenting (EPS)

Treatments via the minor papilla is effective where the deep cannulation via the major papilla is impossible in such cases as [1] the Wirsung's duct is inflammatory narrowed, bent or obstructed by impacted stones [2] pancreatic duct divisum (complete or incomplete) [3], maljunction of pancreatico-biliary union with stones [4], pancreatic stones in the Santorini's duct. In [1,2] cases, the pancreatic juice flow via the major papilla decreases, while that of the minor papilla increases. Then the size of minor papilla and its orifice shows corresponding enlargement. This substitutional mechanism is an advantage when undertaking our new method. Since the pancreatic juice flow is maintained via the minor papilla in these cases, accurate and careful endoscopic skills are necessary to prevent pancreatitis due to the occlusion of the Santorini's duct after this procedure. We have experienced 135 cases treated via minor papilla in these 27 years, so we would like to report about its safety and efficacy.

Research Article **Published Date:-2019-06-07 00:00:00**

Transcatheter Arterial Embolization for the treatment of upper gastrointestinal bleeding

Background: Transcatheter arterial embolization can be used for patients with recurrent bleeding from the upper gastrointestinal tract after failed endoscopic treatment. Our aim to identify the clinical and technical factors that influenced the outcome of transcatheter embolization for therapy of upper gastrointestinal bleeding after failed surgery or after failed endoscopic treatment in high risk surgical patients.

Methods: We performed a prospective study to analysis of the 15 patients who underwent Transcatheter arterial embolization for nonvariceal upper gastrointestinal bleeding at Alshifa hospital from January 2015 to March 2019.

The following variables were recorded: demographic data, time from bleeding start to TAE, units of packed red cells before TAE and units of packed plasma before Transcatheter arterial embolization and we analysis 30 days rebleeding rates and mortality.

Results: Patients treated with Transcatheter arterial embolization (median age: 62 years, range: 14–79 years).The technical success rate of the embolization procedure was 100%. Time from bleeding start to TAE was 2.1 (1-4) days , units of packed red cells before Transcatheter arterial embolization was 12.8 (4-22) packed and units of packed plasma was 3.2 (2-5) packed. Following 30 days after embolization, 2 (13%) patients had repeated bleeding and 3 (20.0%) patients died.

Conclusion: In our experience, arterial embolization is a safe and effective treatment method for upper gastrointestinal bleeding and a possible alternative to surgery for high-risk patients.

Case Report **Published Date:-2019-04-26 00:00:00**

An uncommon cause of isolated ascites: Pseudomyxoma peritonei

Pseudomyxoma peritonei (PMP) or Gelatinous Peritoneal Disease is a rare condition that refers to an anatomo-clinical entity characterized by ascites of variable abundance in the peritoneal cavity, viscous or mucinous, associated or not with neoplastic epithelial cells. It predominates in women. Diagnosis is guided by imaging and confirmed by histology. Prognosis is good in case of early management. We report the case of a male diagnosed with Pseudomyxoma peritonei revealed by isolated ascites.