Gastroenterology Symposium

Thursday 21 November 2019

Bowel cancer update: are we FIT enough? – Professor Bob Steele

Q. Does the source of bleeding from git has any impact on result of FIT and does it help on hidden upper git cancers?

A. Because FIT detects globin, and this is degraded throughout the GI tract, FIT is not effective at picking up bleeding from upper GI lesions.

Liver transplantation: "For the greater good?" – Dr Joanna Leithead

Q. A minimum of 25% of liver is able to function, what are the consequences of transplanting only a part of liver for adults? Since right lobe holds about 65% of total liver size, moreover the transplanted liver would regrow.

A. In general when we are doing split liver transplantation, only an extended right lobe will be used in a relatively small adult recipient – and we only split good quality livers. If the liver quality is suboptimal or the volume of liver transplanted is too small then the patient will develop small for size syndrome – which resembles liver failure and is accompanied by an increased risk of death from sepsis. As you say, the liver will regenerate with time – can fill the space within 6 weeks! In living donation there is more precise calculations of liver volume relative to the recipient – because a smaller lump of liver is available.

Q. What about the hepatic toxicity of immuno suppressive drugs in a transplant patient; how do you guys cope with that problem and have you lost any patient to it?

A. It is extremely rare that we see hepatotoxicity from the immunosuppressive agents (I have seen only a few in 15 years of working in transplant centres!). The most common effect we see is nodular regenerative hyperplasia relating to azathioprine. What is far more common is extrahepatic side effects e.g. nephrotoxicity from tacrolimus/cyclosporine, bone marrow toxicity, pneumonitis from sirolimus etc.

Elimination of Hepatitis C: learning from Egypt – Professor Manal El-Sayed

Q. How do patients become infected in first place and is there a strategy to prevent patients becoming infected?

A. Originally Egyptians were infected with HCV through the mass parentral antischistosomal therapy campaigns in the villages given in the 50S, 60s and 70s (tartar emetic) and only glass syringes were available during this period and were boiled.

The infection was sustained in the community through both nosocomial transmissions, interfamilial spread and blood transfusions.

Now, we have a strategy and action plan developed with technical support of WHO and CDC and we are introducing the safety engineered devices for safe injection practices, infection control in hospitals has improved dramatically after the strategy was developed and blood safety is on top of the presidential priorities after discussing this with the Government to ensure all blood units are screened by NAT testing rather than only 30% coverage by NAT and rest by ELISA testing. There are

continuous campaigns also in Barber shops to certify them and make sure the practices are safe and there is huge awareness among the community members concerning modes of transmission and how to avoid infections with blood borne pathogens. Our major challenge remains to be surveillance and which POC to use in surveillance.

An update on mesenteric ischaemia – Mr Wesley Stuart

Q. If patient comes in with acute abdo generally get a basic CT. is this enough or do your patients get CT angio?

A. Contrast CT is usually enough. These tend to be portal venous phase CTs, but this usually shows arteries enough for diagnosis. On occasional arterial phase contrast is required before radiological intervention. There is a need to balance competing issues: time, expertise, impact on renal function and ideal imaging.

Q. Is there any role of tissue plasminogen activator in acute mesenteric ischemia?

A. Lysis in any form could be used, but if established necrosis is suspected or a laparotomy is planned immediately (as is usually the case in acute presentations) bleeding complications would be likely with systemic thrombolytic therapy.