# ADVERSE EVENTS OF UNSEDATED ESOPHAGOGASTRODUODENOSCOPY IN SICK PATIENTS: THE IMPACT OF TOPICAL LIDOCAINE

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**Background and aims: Pharyngeal anesthesia by using topical lidocaine is generally used as pretreatment for unsedated esophagogastroduodenoscopy (UEGD). The aim of this study was to compare and evaluate the adverse events of topical lidocaine for pharyngeal anesthesia when the topical lidocaine is used as a single agent for unsedated esophagogastroduodenoscopy (UEGD) between sick and non-sick patients. Patients and methods: Retrospectively analyzed the patients on whom UEGD procedure had been performed during the period of December, 2007 to April, 2009 in Siriraj Hospital. Patients were categorized into two groups. Group A was the patients who had ASA physical status I, II. Group B was the patients who had ASA physical status III, IV. The primary outcome variable was the adverse event rate. The secondary outcome variables were anesthesia and procedure related complications, and mortality rate. Results: There were 1,398 patients who underwent UEGD during the study period. After matching gender, duration of procedure and indications of endoscopy, there were 422 patients in group A and 418 patients in group B. All anesthesia was given by residents or anesthetic nurses directly supervised by staff anesthesiologist in the endoscopy room. There were no significant differences in gender, weight, height, duration of procedure, indications of procedure, and overall adverse rate as well as anesthesia and procedure related complications between the two groups. Mean age in group B was significantly higher than in group A. All complications were comparable, easily treated, with no adverse sequelae. Conclusions: Topical lidocaine for pharyngeal anesthesia in sick and non-sick patients provided effective and safe for UEGD procedure. All adverse events in both groups were comparable, mild degree and easily treat. No serious adverse events were observed.**

# ALTERATIONS IN LIPOPROTEIN PATTERNS AND LIPID PEROXIDATION IN EGYPTIAN PATIENTS WITH HEPATOCELLULAR CARCINOMA: CORRELATION WITH CHILD - PUGH AND MELD SCORE.

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**Background/aim: Hepatocellular carcinoma (HCC) constitutes the 5th most frequent cancer worldwide. Liver is one of the most important organs in energy metabolism and plays a critical role in both the production and catabolism of lipids, lipoproteins and apolipoproteins. This study was aimed to analyze the plasma lipid profile as well as C-reactive protein (CRP) and Malondialdehyde (MDA) among Egyptian patients with chronic HCV infection suffering from HCC and its correlation with Child-pugh and MELD score Methods: This study was carried out on 91 patients (52males, 39 females) with HCC and 90 cirrhotic controls. The patients were classified according to Childâ€“pugh classification into Child A (n=26),B(n=31) and C(n=34), according to MELD score into 32 patients â‰¤ 9 and 59 > 9 and according to size of HCC into 33 patients â‰¤ 5cm and 58 patients >5cm . plasma lipid profiles , MDA and CRP were determined by conventional methods. Results: plasma levels of Cholesterol, triglycerides (TG), low-density lipoproteins (LDL), high-density lipoproteins (HDL) were significantly decreased in patients with HCC than control (p=0.005,0.005,0.008 and 0.009) respectively, however CRP and MDA are significantly increased compared to control (p=0.006). With progression from Child A to Child C there were significant decrease in lipids profiles and significant increase in CRP and MDA. In MELD score â‰¤ 9 lipids profiles were significant increases when compared with MELD score > 9. Whereas in CRP and MDA showed significant decreases in MELD score â‰¤ 9 than MELD score > 9 (p=0.045 and 0.001). Lipids profiles were significant increase in HCC â‰¤ 5cm than HCC> 5cm; however CRP and MDA showed significant decreases in HCC â‰¤ 5cm than HCC> 5cm. Conclusion: There were significant alteration in the plasma lipid profiles, MDA and CRP parameters in patients with HCC and could be used as prognostic value.**

# ANESTHESIA FOR ENTEROSCOPY PROCEDURE IN A TERTIARY CARE TEACHING HOSPITAL IN THAILAND

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**Background and aim: Enteroscopy procedure is another diagnosis and treatment option for gastrointestinal tract abnormalities. The authors studied anesthetic data as a basis for further research. Patients and methods: Retrospectively analyzed the patients on whom enteroscopy procedure had been performed during the period of March, 2005 to November, 2010 in Siriraj Hospital. The patientsâ€™ characteristics, preanesthetic problems, anesthetic techniques, anesthetic agents, anesthetic time, ERCP procedure and complications were assessed. Results: There were 145 patients who received the procedure during study period. The age group of 50-69 years was the highest one (46.9%). Most patients had ASA class II (57.2%). The indications of procedure were gastrointestinal bleeding (58.6%), chronic diarrhea (15.2%), protein losing enteropathy (2.1%) and others (24.1%). Hematologic disease, cardiovascular disease and hypertension were the most common pre-anesthetic problems. General anesthesia and intravenous sedation was the anesthetic technique mainly employed. Anesthetic agents were mainly administered with propofol, midazolam and fentanyl. The mean anesthetic time was 92.8Â±48.4 minutes. The indications for enteroscopy procedure were gastrointestinal bleeding (58.6%), chronic diarrhea (13.8%), protein losing enteropathy (2.1%) and others (15.5%). Single balloon and oral intubation was the most common type and route of enteroscopy. The most frequent anesthetic complication was hypotension. Conclusion: During anesthetic management for enteroscopy procedure, special techniques or drugs in anesthesia are not routinely required, however, the anesthetic personnel had to optimize the patientâ€™s condition for safety and there should be an awareness of complications.**

# COLORECTAL SCHISTOSOMIASIS: IS IT STILL ENDEMIC IN DELTA EGYPT EARLY IN THE 3RD MILLENNIUM?

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**Schistosomiasis is still frequently encountered in clinical practice with its advanced sequalae, despite progress in health education and mass antischistosomal chemotherapy. This study is a trial to evaluate the role of endoscopy in the diagnosis of colorectal schistosomiasis. Patients and methods: This study evaluates patients presented to the gastroenterology unit with different gastrointestinal symptoms by endoscopic examination where 3-6 tiny biopsies were taken from those with visible, suspected schistosomal lesions for histopathological examination by paraffin section and 2 additional rectal biopsies were taken for crush biopsy(squash technique)even with endoscopically apparently normal colonic mucosa. For each patient, at least 3 stool samples were examined by the Formal ether concenteration method for schistosoma ova. Results: Colonic abnormalities was detected in510 out of 984 patients presented with different gut symptoms. Schistosoma mansoni was detected in 205 patients (180 males, 25 females) the age range (18--65years). Six patients only had schistosomal polyps at the sigmoid colon and excised successfully by snare polypectomy. Squash technique established the diagnosis of schistosomiasis in all endoscopically normal 118 (50.75%)cases with by demonstrating the schistosomiasis ova and their histopathological findings showed no or minimal reaction in 96 (46.82%) cases and variable degrees of submucosal granulomata in the remaining cases. Stool examination found the schistosomiasis ova in 25 (9.83%) patients only of the biopsy**

**positive cases . Colon or rectal cancer cases were all schistosomiasis free. Conclusions: Our data revealed that the endoscopic crush biopsy proved to be simple and effective method to detect acute and chronic Schistosomiasis even with endoscopically normal colonic mucosa and negative stool examination. In endemic areas, the squash technique is preferably adopted to pick up early treatable cases and prevent the chronic in**

# EXPERIENCE OF PROPOFOL-BASED DEEP SEDATION FOR ERCP AND EUS PROCEDURES IN GERIATRIC PATIENTS IN THAILAND

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**Background and aim: Gastrointestinal endoscopy (GIE) procedures in geriatric patients are rising and play an important role for diagnosis and management of various gastrointestinal diseases. The use of deep sedation in these patients has been established as a safe and effective technique in Western countries. It is uncertain if the situation holds true among Asians. This study aimed to evaluate the outcome of propofol-based deep sedation (PBDS) for ERCP and EUS procedures in geriatric patients (â‰¥65 years old) and to compare the clinical efficacy of PBDS between the very old patients (>80 years old) and those younger (â‰¤80 years old) for this procedure in a tertiary-care teaching hospital in Thailand. Material and Methods: We undertook a retrospective review of the anesthesia or sedation service records of patients who underwent GIE procedures. All procedures were performed by senior endoscopists and fellows in GI endoscopy. All sedations were administered by anesthetic personnel in the endoscopy room. Results: Sedation was provided for 1,779 patients in 2,061 GIE procedures. Of these, 252 patients (mean age, 45.1 (11.1) years, range 17-65 years) were in the younger than 65 years old group, 209 patients (mean age, 71.7 (4.3) years, range 65-80 years) were in the age 65-85 years old group, and 30 patients (mean age, 84.6 (4.2) years, range 81-97 years) were in 81 years of age and older group. Common indications for the procedures were cholelithiasis (30.0%) in the very elderly and pancreatic tumor (33.7%, 20.1%) in the younger, respectively. The majority of pre-sedation problems were hypertension, hematologic diseases and diabetes mellitus. Fentanyl, propofol and midazolam were the most common intravenous sedative drugs used in all three groups. Mean dose of propofol and midazolam in the very old patients was statistically significantly lower than the other young groups. The combination of propofol, midazolam and fentanyl as well as propofol and fentanyl**

# HEPATICO-ENTERO-GASTROSTOMY; A MODIFIED BILIARY SHUNT FOR BENIGN STRICTURE WITH FACILITATED FUTURE ENDOSCOPIC ACCESS

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**Background: Hepaticojejunostomy is the classical reconstruction for benign biliary stricture. Endoscopic management of anastomotic complications after hepaticojejunostomy is extremely difficult except if an access loop is constructed. Different types of access loops were tried. In this work we assess a modified biliary shunt in the form of hepatico-entero-gastrostomy (HEG) that could be used for endoscopic follow up of the shunt and management of its complications. Methods: From October 2008 till June 2010 all patients presented to the authors with benign biliary stricture who needed bilio-enteric shunt were considered. For each patient hepatico-entero-gastrostomy (HEG) of either type I, II or III was performed. In the fourth week postoperatively endoscopy was performed to explore the possibility to access the biliary anastomosis and perform cholangiography. The patients were followed up afterwards for any complications and their management. Results: HEG shunt was performed for fourteen patients, one of whom died due to myocardial infarction leaving thirteen patients with a diagnosis of postcholecystectomy biliary injury (8), inflammatory stricture with or without choledocholithiasis (4) and strictured biliary shunt (1). HEG shunts were either type I (3), type II (4) or type III (7). Endoscopic follow up revealed successful access to the anastomosis in 11 patients (84.6%), while the access failed in one type I and one type II HEG (15.4%). Mean time needed to access the anastomosis was 15.2 min (2-55min). On a scale from 1-5, mean endoscopic difficulty score was 2.5. One patient developed anastomotic stricture after 18 months that was treated endoscopically by stenting. In relation to the other types, type III HEG was faster to access endoscopically, easier and with no failure. Conclusion: HEG, which is a modified biliary shunt, facilitates endoscopic access of the anastomosis and management of its complications and could be considered for biliary reconstruction**

# IMPACT OF MULTISLICE SPIRAL COMPUTED TOMOGRAPHY ON DONOR SELECTION AND SURGICAL PLANNING IN LIVING-RELATED LIVER TRANSPLANT

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**Objectives: Living-donor liver transplant is used with increasing frequency to help compensate for the increasing shortage of deceased-donor liver grafts. However, donor safety is a primary concern, and selection of the preoperative imaging modality is important in preserving donorâ€™s health by excluding unsuitable candidates, and tailoring the surgical procedure according to anatomic variations. In this study, we evaluate the impact of Multislice spiral computed tomography on potential donor selection and surgical planning before living-related-liver transplant. Materials and Methods: One-hundred seventy-five potential living-liver donors (62 women and 113 men; age range, 23-34 years; mean, 32 years) were included in our study. All subjects underwent multiphasic multislice spiral computed tomography. Post-contrast acquisitions were obtained for the arterial and venous phases. There were 139 potential donors for the right lobe and 36 potential donors for the left lateral segment. All data were analyzed to detect vascular variants, exclude focal liver lesions, and determine hepatic volume, and preoperative findings were correlated with intraoperative findings in 65 patients. Results: Of the 175 potential liver donors evaluated with multislice spiral computed tomography, 56 (32%) were excluded for the following reasons:- portal vein anomalies in 11(19.6%), hepatic venous anomalies in 9 (16.1%), fatty liver in 17(30.3%), small liver volume in 12 (21.4%),and a focal lesion in the liver in 7 (12.5%). Of the 65 candidates, surgical planning and technique were modified in 24 donors and recipients, in 23 candidates and the donor only in 1 candidate. Conclusions: Multislice spiral computed tomography provides parenchymal, vascular, and volumetric preoperative evaluation of potential donors for living-related liver transplant and has an effect on surgical planning: It allows the surgeon to reduce postoperative complications by modifying the surgical technique.**

# MIGRATING BILIARY STENT INTO RETROPERITONEUM -- AN UNUSUAL COMPLICATION OF ENDOSCOPIC BILIARY STENTING

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**Endoscopically placed biliary stents have supplanted surgical decompression as the preferred treatment option for patients with obstructive jaundice from calcular Cholecystitis or malignant pancreatic cancer. Endoscopic biliary stent placement is a well established, safe and minimally invasive modality for the treatment of biliary diseases such as choledocholithiasis. Over the past decade the use of this modality has increased. Despite the overall safety of this modality, on rare occasions these stents may migrate from the biliary tract. A small percentage of those stents perforate the gut and require surgical intervention. An unusual complication of indwelling biliary stents is duodenal perforation into the retro peritoneum. We describe a case of 76-year old woman patient who presented with left hypochondrial pain and high grade fever from erosion through the wall of the second portion of the duodenum of a previously placed bile duct stent.**

# PAIN SCORE WITHIN TWENTY-FOUR HOURS POST-THERAPEUTIC ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY DOES NOT DEPEND ON ANESTHETIC TECHNIQUE

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**Aim: To assess and compare the pain scores after early (24 hour) post-therapeutic endoscopic retrograde cholangiopandreatography (ERCP) of adult patients underwent general anesthesia and intravenous sedation. Patients and Methods: Prospectively analyzed the patients on whom therapeutic ERCP were performed during the period of March, 2007 to February, 2008 in Siriraj GI Endoscopy Center. A total of 202 endoscopies were performed by three endoscopists. Of these, 25 patients were done with general anesthesia technique (group GA) and 177 patients with intravenous sedation technique (group IVS). Pain scores were compared by using visual analog scale (VAS, 0-100) and the total dose of pethidine used for pain control after ERCP. Results: After matching ASA physical status, indication and interventions of procedure, there were 25 ERCP procedures in group GA and 73 ERCP procedures in group IVS. The mean pain score at baseline was not significantly different between the two groups. The mean pain scores at 2, 6, 12, 18 and 24 hours post-ERCP in both groups were not significantly different. The total dose of pethidine used for pain control after ERCP in both groups was not significantly different. Conclusion: Pain score within twenty-four hours post-therapeutic ERCP does not depend on anesthetic technique. Therapeutic ERCP-induced abdominal pain in general anesthesia and intravenous sedation technique is comparable. Pain scores in both groups are low.**

# PAIN SCORE WITHIN TWENTY-FOUR HOURS POST-ENDOSCOPIC ULTRASONOGRAPHY: A COMPARISON OF IMAGING STUDY WITH OR WITHOUT FINE NEEDLE ASPIRATION PROCEDURE

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**Background and aim: To compare the pain score within twenty-four hours post-endoscopic ultrasonography (EUS) between the diagnostic with or without fine needle aspiration (FNA) procedure in adult patients. Patients and methods: We prospectively analyzed the patients who underwent EUS from January, 2009 to December, 2009. Pain score was compared by using visual analog scale (VAS, 0-100) and pain relief medications at 2, 6, 12, 18, 24 hour post-procedure. Results: One hundred and twenty-four patients, 40 patients only with a diagnostic procedure (group D) and 84 patients with a diagnostic and FNA procedure (group F), were enrolled. All procedures were completed successfully. Sedative agents in both groups were propofol, midazolam and fentanyl and were comparable dose among the two groups. The mean procedural time in D and F was 39.8Â±19.1 and 60.6Â±26.0 minutes, respectively. Mean pain score at base line and at 2, 6, 12, 18 and 24 hour post-EUS was not significantly different between the two groups. Additionally, total dose of pethidine used for pain control after ERCP in both groups was not significantly different. Conclusion: EUS-induced abdominal pain is mild and mainly occurs within six hours after the procedure. Pain score within twenty-four hours post-EUS after the diagnostic with or without fine needle aspiration procedure is comparable.**

# PREVENTION OF PANCREATIC FISTULA POST PANCREATICODUODENCTOMY

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**Significant improvement in mortality following pancreatico-dudoenctomy has been noted in recent years .Despite this, morbidity remains high .Pancreatic fistula is a most feared complication after pancreatico-duodenectomy , numerous strategies have been employed to overcome this problem. Whether one chooses a duct to mucosa 2 layers anastomosis or a single layer dunking technique , doesn't seem to differ in occurrence of post operative pancreatic fistula. Other strategies have included the use of prophylactic octeoretide ,still results are variable among different series. It appears that a standardized approach to the to the pancreatic anastomosis of a single technique and experience of the team ,and other intraoperative parameters can help to reduce the incidence of such complication.**

# SURGERY VS. ENDOSCOPY. COMPETITIVE OR COMPLEMENTARY TOOLS FOR MANAGEMENT OF POSTCHOLECYSTECTOMY PROBLEMS. 10 YEARS' EXPERIENCE IN MAJOR REFERRAL CENTER.

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**Purpose: A prospective work to study and evaluate surgical and endoscopic techniques used in management of post cholecystectomy problems. Patients & Methods: In the period from Mars 2000 to October 2009, a random sample of 630 patients (366 females and 264 males) were collected from general surgery department, and gastro-intestinal endoscopy unit, Assuit University hospitals, and managed accordingly using surgery in 143 patients, and endoscopy in 482 patients (plus percutaneous techniques in 25 patients). Results: Endoscopy was very successful as an initial treatment of 457 patients (73%), as being less invasive, low morbidity and mortality, competitive to surgery in treatment of missed stone (88%), mild to moderate biliary leakage (82%), and biliary stricture (74%). Its success increased by addition of percutaneous techniques in 4%, 2.8% & 8.3% for missed stone, leakage, and stricture respectively. But endoscopy was somewhat complementary to surgery in major leakage, and massive stricture, and surgery was resold to in 15%, and 17% of cases. Surgery remain as the treatment of choice in complex problems, and endoscopy play a complementary role in such cases of transection, ligation, combined problems of stones, stricture, and leakage (< 40%), compared to 60% for surgery. Bilio-enteric anastomosis was the procedure of choice, done 86 cases, with stent splintage in unhealthy, or small sized ducts. And stricture complication was encountered in 6% of cases treated by percutaneous rout in 4, and redo surgery in1 case. The learning curve seems influential in both endoscopy and surgery. The cumulative experience increase the success rate of endoscopy from initial 50% to 95%nowadays, also surgery improved with decreased morbidity and mortality as complications encountered was seen in initial experience and decreased with time. Conclusion: Endoscopy was competitive to surgery in simple problems and advised to be the initial treatment choice.**

# SYNCHRONOUS CAECAL ADENOCARCINOMA AND MULTIPLE COLONIC IN SITU CARCINOMAS IN HAMARTOMATOUS POLYPS IN A YOUNG EGYPTIAN FEMALE PATIENT WITH ISOLATED PEUTZ-JEGHERS SYNDROME PRESENTED INITIALLY WITH HAEMATOCHEZIA: A CASE REPORT

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**Peutz-Jeghers' syndrome (PJS) is a rare autosomal dominant disease characterized by mucocutaneous pigmentation and hamartomatous polyps of the entire gastrointestinal tract. A PJP in a patient without pigmentation or a family history of the disease is called an isolated or solitary PJP. Individuals with PJS carry a very high risk of developing gastrointestinal (GI) as well as extra-GI malignancies. This case report documents lesion multiplicity and their malignant potential in a young patient with PJS coming for the first time with a serious presentation. Case report: A 18-year-old female Egyptian female patient was admitted with haematochezia and remarkable anaemia. After appropriate resuscitation and consent, colonoscopic evaluation revealed seven pedunculated colonic polyps at the ascending and the transverse colon and numerous variable sized sessile ones were scattered all over the colon. To establish haemostasis, endoscopic polypectomy for pedunculated polyps and argon plasma photocoagulation for the sessile bleeding ones were performed. Histopathological examination revealed caecal adenocarcinoma in one specimen and two simultaneous in situ carcinoma at the transverse and the sigmoid colon in the mucosae of the excised hitologically proven hamartomatous polyps. Additionally, one focal in situ carcinoma in the resected colon was detected. Conclusions: When considering the family history, serious gastrointestinal neoplastic lesions may be unmasked in young patients with PJS presented with haematochezia even in absence of its characteristic muco-cutaneous pigmented lesions. GI endoscopic surveillance programs would be adopted for diagnosed cases of PJS and their families. Genetic prenatal screening for early detection is the best option for primary prevention.**

# TACE PRIOR TO CT-GUIDED PERCUTANEOUS ABLATION IN CRITICAL HCC CONFIGURATIONS

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**The effectiveness of RFA as a primary and single line therapy for HCC < 3 cm is well-established in the current literature, with long term outcomes and 5 years survival comparable to surgical resection, while still providing all the advantages of a minimally invasive percutaneous approach. Nevertheless, the same facts do not apply for tumors from 3-5 cm. Moreover, in some particular situations of tumors < 3 cm, RFA can be less than satisfactory. In these particular situations such as Juxta-vascular location, invisibility on U/S, hidden hepatic dome locations, locations adjacent to vital organs, suspected daughter nodules and/or infiltrative rather than nodular tumor patterns, providing TACE prior to RFA may have beneficial impact on tumor control. Moreover, Lipiodol accumulation may provide a perfect target for needle placement, performed under dual U/S and CT-guidance with the combined advantage of increasing safety and efficacy for treating critical HCCs. We are hereby presenting our initial experience in Alexandria university in treating 20 patients with critical HCCs having relative contra-indications to RFA using (TACE + CT guided RFA) combination therapies.**

# TRANSPARENCY AND LIVING DONOR LIVER TRANSPLANTATION IN EGYPT

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**The number of LDLT procedures performed annually has increased rapidly in the past few years. In January, 2010, the number of living donor liver transplants performed topped out to more than one thousand procedures, done in 11 centers. The case number 1000 had been performed in the National Liver Institute in Menoufeyia. No surgical intervention is completely safe, and death may complicate any intervention. Liver donation puts the donor at risk of medical and surgical complications and even death. In order to promote living donation, and in fairness to the patients in need, absolute clarity about the risks and benefits of this approach is mandatory. This obligation to all living donors includes long term follow up to identify any problem that may be associated with their operation. Potential living liver donors are best served by accurate information derived from genuine transparent collaborative effort between centers.Transplant centers must be fully aware of their own responsibility: being honest to themselves and their patients. Secrecy is unacceptable, as it leads to gossip and speculation by others.**