RADISSON BLU HOTEL, ALEXANDRIA
May 7-9, 2015

Gastro Club Meeting

The Egyptian Society of Hepatology, Gastroenterology and Infectious Diseases in Alexandria

SCIENTIFIC PROGRAM

THURSDAY, MAY 7th, 2015

17:00 - 17:15 Opening Ceremony	
Prof. Siham Abdel-Rehim	Secretary of the Congress
Prof. Yousry Taher	President of the Congress
Prof. Magdy Hegazy	Deputy Minister of Health, Alexandria
Prof. Hilmy Abaza	President of the Society

17:15 - 17:45 Session I: Short Update Lectures		
Chairpersons	**Ahmed El-Garem** Cairo University **Fathalla Sedki** Alexandria University **Sherif Abdel-Fattah** Military Medical Academy	
17:15 - 17:30	HCV treatment by DAAs: Case study	**Sherif Abdel-Fattah** Military Medical Academy
17:30 - 17:45	Recent advances in GERD management	**Amr Fateen** Ain Shams University

17:45 - 18:45 Session II: Surgical Problems in GIT		
Chairpersons	**Ahmed Shawky** Alexandria University **Hassan El-Bahrawy** Alexandria University **Mohamed Kasem** Alexandria University	
17:45 - 18:00	Acute Abdomen after bariatric surgery	**Saied El-Kayal** Alexandria University
18:00 - 18:15	Budd Chiari Syndrome is it a treatable disease	**Ahmed Zaid** Alexandria University
18:15 - 18:30	Complications of gastric plication surgery	**Mohamed Sharaan** Alexandria University
18:30 - 18:45	Laparoscopic hepatic resection	**Ahmed El-Gendy** Alexandria University

18:45 - 19:30 Session III: Hepatitis B update		
Chairpersons	**Alaa Abdo** Alexandria University **Amr Fateen** Ain Shams University **Yousry Taher** Alexandria University	
18:45 - 19:00	Clinical uses of HBsAg quantification	**Mahmoud Anis** Tanta University
19:00 - 19:15	HBV management in lymphoma	**Abdel-Fattah Hanno** Alexandria University
19:15 - 19:30	Hepatitis B and pregnancy	**Hassan Hamdy** Ain Shams University

19:30 - 20:00 Session IV: AstraZeneca Symposium		
Chairpersons	**Hilmy Abaza** Alexandria University **Yousry Taher** Alexandria University	
19:30 - 20:00	PPIs and gastritis	**Fathalla Sedki** Alexandria University

20:00 - 21:00 Session V: HCC Management Debate		
Chairpersons	**Gamal El-Ebeidy** Mansoura University **Ibrahim Boghdadi** Alexandria University **Mohamed Sharaf** Tanta University	
20:00 - 20:15	Hepatologist	**Ahmed Zaid** Alexandria University
20:15 - 20:30	Radiologist	**Omar Aaser** Alexandria University
20:30 - 20:45	Surgeons	**Maher Osman** Menofeya University **Ahmed El-Gendy** Alexandria University
20:45 - 21:00	Oncologist	**Yasser Kerm** Alexandria Research Institute

21:00 - 22:00 Session VI: Case Presentations		
Chairpersons	**Farouk Mekky** Alexandria University **Saied El-Kayal** Alexandria University **Yousry Taher** Alexandria University	
21:00 - 21:10	Postcholecystectomy residual CBD stones surgical decision	**Khalid Abul-Ella** NLI
21:10 - 21:20	Challenging cholecystectomy	**Wael Nabil** Alexandria University
21:20 - 21:30	APC after VBL decrease recurrence of esophageal varices	**Ahmed Kamal** Alexandria University
21:30 - 21:40	Giant epiphrenic diverticulum misdiagnosed and managed as H.H	**Mosaad Anwar** Alexandria University
21:40 - 21:50	Eosinophilic gastroenteritis: case presentation	**Gasser El-Azab** NLI
21:50 - 22:00	**Discussion**	

SCIENTIFIC PROGRAM

FRIDAY, MAY 8th, 2015

Morning Session

10:00 - 11:30 Session I: Update Lectures		
Chairpersons	**Ahmed El-Garem** Cairo University **Mohamed El-Warraki** NLI **Siham Abdel-Rehim** Alexandria University	
10:00 - 10:20	Economic burden of HCV in Egypt	**Ibrahim Boghdadi** Alexandria University
10:20 - 10:40	Malpractice in GIT prescribing	**Mohamed Sharaf** Tanta University
10:40 - 11:00	NASH and HCC	**Adel El-Rakeeb** Al-Azhar University
11:00 -11:20	Left sided gallbladder	**Galal Abul-Naga** Alexandria University
11:20 - 11:30	Discussion	

Afternoon Sessions

17:00 - 17:30 Session II: Short Update Lectures		
Chairpersons	**Hosny Salama** Cairo University **Magdy Hamed** Mansoura University **Medhat Hosny** Ministry of Health	
17:00 - 17:15	HCV is difficult to eradicate in Egypt …… why?	**Hilmy Abaza** Alexandria University
17:15 - 17:30	Practical challenge in management of hepatitis C	**Mohamed Kahla** NLI

17:30 - 18:30 Session III: Case Presentation			
Chairpersons	**Ahmed Shawky** **Khalid Abul-Ella** **Mohamed Kasem**	Alexandria University NLI Alexandria University	
17:30 - 17:45	A difficult Choledochal cyst management		**Maher Osman** Menofeya University
17:45 - 18:00	Right iliac fossa abcesss ? cause		**Mohamed Sharaan** Alexandria University
18:00 - 18:15	Up to date laparoendoscopic extraction of CBD stones		**Abdel-Hameed Ghazal** Alexandria University
18:15 - 18:30	Khat induced liver disease 2 case presentation		**Mohamed Kahla** NLI

18:30 - 19:00 Session IV: Janssen Symposium			
Chairpersons	**Ibrahim Mostafa** **Siham Abdel-Rehim**	TBRI Alexandria University	
18:30 - 19:00	Simprevir (Olysio) in HCV management (Interferon free – Ribavirin Free)		**Gamal Esmat** Cairo University

19:00 - 20:00 Session V: Biliary and Colon Surgical Problems			
Chairpersons	**Fathalla Sedki** **Ibrahim Boghdadi** **Farouk Mekky**	Alexandria University Alexandria University Alexandria University	
19:00 - 19:15	Gallbladder Gangrene learning from pitfalls		**Wael Nabil** Alexandria University
19:15 - 19:30	Post biliary surgery persistent severe abdominal pain dilemma of surgical decision and diagnosis		**Ahmed Shawki** Alexandria University
19:30 - 19:45	Subcutaneous perplexing lesions, two case presentations		**Khalid Katri** Alexandria University
19:45 - 20:00	Bleeding per rectum misdiagnosed as angiodysplasia		**Mohamed El-Warraki** NLI

20:00 - 21:00 Session VI: Miscellaneous		
Chairpersons	**Ahmed El-Garem** Cairo University **Hilmy Abaza** Alexandria University **Ibrahim Mostafa** TBRI	
20:00 - 20:15	Fulminate hepatitis in the third trimester dilemma of management	**Brihan El-Sayed** Alexandria University
20:45 - 21:00	Large bowel bleeding, is it safe to embolize?	**Hassan Abdel-Salam** Alexandria University
20:15 - 20:30	Vasculitis syndrome: A rare cause	**Nermin Sherif** Alexandria University
20:30 - 20:45	intestinal intussusception in adults	**Tamer Abdel-Baki** Alexandria University

21:00 - 22:00 Session VII: Case Presentation		
Chairpersons	**Alaa Abdo** Alexandria University **Hassan El-Bahrawy** Alexandria University **Yousry Taher** Alexandria University	
21:00 - 21:15	Mirrizzi syndrome, imaging and surgical aspects	**Farouk Mekky** Alexandria University
21:15 - 21:30	Black tongue significance	**Shimaa Sobhi** Alexandria University
21:30 - 21:45	A rare infectious cause for intrahepatic Cholestasis	**Hend Naguib** Alexandria University
21:45 - 22:00	Acute portal vein thrombosis how to manage	**Doaa Hassan** Alexandria University

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Ceftriaxone may be used alone or in combination with another anti-bacterial agent for the prophylaxis of postoperative infections associated with cardiovascular surgery or urological procedures and in colorectal surgery. In colorectal surgery ceftriaxone should be used in combination with another antibiotic that can provide anaerobic coverage. **Dosage:** The dose and route of administration should be determined by the severity and site of infection, susceptibility of the causative micro-organism and the patient's age and condition. As with antibiotic therapy in general, administration of ceftriaxone should be continued for at least 48-72 hours after the patient has become afebrile or evidence of bacterial eradication has been obtained. **Adults and adolescents aged over 12 years with a body weight ≥ 50 kg** The usual dose is 1-2 g of ceftriaxone, administered once a day (every 24 hours). In cases of serious infections or infections caused by moderately sensitive microorganisms the dose can be increased to 4 g administered once a day. **Neonates and children up to 12 years of age with a body weight of < 50 kg.** The following dosage schedules are recommended for once daily administration: Neonates: The recommended daily dose is 20-50 mg/kg body weight, given intravenously over 60 minutes. The dose must never exceed 50 mg/kg body weight. The dose is the same for premature and full-term newborn infants. Infants and children up to 12 years: The recommended daily dose is 20-50 mg/kg body weight, but up to 80 mg/kg daily may be administered in very severe infections. A daily dose of 80 mg/kg must not be exceeded. Intravenous doses over 50 mg/kg body weight should be given by infusion, over a period of 30 minutes. For children with a body weight of 50 kg or more, standard adult dosing is recommended. **Method of administration:** Ceftriaxone may be administered by intravenous bolus injection, by intravenous infusion or by intramuscular injection after reconstitution of the solution according to the directions below. Diluents containing calcium, (e.g. Ringer's solution or Hartmann's solution), should not be used to reconstitute ceftriaxone vials or to further dilute a reconstituted vial for IV administration because a precipitate can form. Precipitation of ceftriaxone-calcium can also occur when ceftriaxone is mixed with calcium-containing solutions in the same IV administration line. Therefore, ceftriaxone and calcium containing solutions must not be mixed or administered simultaneously. Ceftriaxone should not be mixed in the same syringe with any drug other than 1% lidocaine hydrochloride solution (for intramuscular injection only). When reconstituted for intramuscular or intravenous injection, the white to yellowish-orange crystalline powder gives a pale yellow to amber solution. **Contraindications:** Ceftriaxone is contraindicated in patients with known hypersensitivity to betalactam antibiotics. In patients hypersensitive to penicillin, the possibility of allergic cross-reactions should be borne in mind. Hyperbilirubinaemic newborns and preterm newborns should not be treated with ceftriaxone. In vitro studies have shown that ceftriaxone can displace bilirubin from its binding to serum albumin and bilirubin encephalopathy can possibly develop in these patients. Ceftriaxone is contraindicated in: premature newborns up to a corrected age of 41 weeks (weeks of gestation + weeks of life), full-term newborns (up to 28 days of age), with jaundice, or who are hypoalbuminaemic or acidotic because these are conditions, in which bilirubin binding is likely to be impaired, if they require (or are expected to require) IV calcium treatment, or calcium-containing infusions because of the risk of precipitation of ceftriaxone-calcium. Contraindications of lidocaine must be excluded before intramuscular injection of ceftriaxone when lidocaine is used as a solvent. **Special warnings and precautions for use:** As with other cephalosporins, anaphylactic shock cannot be ruled out even if a thorough patient history is taken. Each gram of ceftriaxone contains 2.6x mmol sodium. To be taken into consideration in patients on a controlled sodium diet. Clostridium difficile associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including ceftriaxone, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of C. difficile. C. difficile produces toxins A and B which contribute to the development of CDAD. Shadows, which have been mistaken for gallstones, have been detected on sonograms of the gallbladder, usually following doses higher than the standard recommended dose. Cases of fatal reactions with calcium-ceftriaxone precipitates in lungs and kidneys in premature and full-term newborns aged less than 1 month have been described. At least one of them had received ceftriaxone and calcium at different times and through different intravenous lines. In vitro studies demonstrated that newborns have an increased risk of precipitation of ceftriaxone-calcium compared to other age groups. In patients of any age ceftriaxone must not be mixed or administered simultaneously with any calcium-containing IV solutions, even via different infusion lines or at different infusion sites. If use of ceftriaxone is considered necessary in patients requiring continuous nutrition, TPN solutions and ceftriaxone can be administered simultaneously, albeit via different infusion lines at different sites. Alternatively, infusion of TPN solution could be stopped for the period of ceftriaxone infusion, considering the advice to flush infusion lines between solutions. Cases of pancreatitis, possibly of biliary obstruction etiology, have been rarely reported in patients treated with ceftriaxone. Most patients presented with risk factors for biliary stasis and biliary sludge, e.g. preceding major therapy, severe illness and total parenteral nutrition. A trigger or cofactor role of ceftriaxone related biliary precipitation cannot be ruled out. In severe renal and hepatic insufficiency, dosage should be reduced according to given recommendations. During prolonged treatment complete blood count should be performed at regular intervals. In case lidocaine is used as a solvent ceftriaxone solutions should only be used for intramuscular injection. **Undesirable effects:** The undesirable effects usually are mild and short-term in: Systemic side effects: gastrointestinal complaints (about 2% of the cases): loose stools or diarrhea, nausea, vomiting, stomatitis and glossitis. Hematological changes (about 2%): eosinophilia, leukopenia, granulocytopenia, hemolytic anemia, and thrombocytopenia. Unknown frequency: cases of agranulocytosis (< 500/mm3) have been reported, most of them after 10 days of treatment and following total doses of 20 g or more. Skin reactions (about 1%): exanthema, allergic dermatitis, pruritus, urticaria, edema. Unknown frequency: severe cutaneous adverse reactions (erythema multiforme, Stevens Johnson syndrome or Lyell's Syndrome/toxic epidermal necrolysis) have been reported. Other, rare side effects: headache, vertigo and dizziness, symptomatic precipitation of ceftriaxone calcium salt in the gallbladder, increase in liver enzymes, glucosuria, hematuria , oliguria, increase in serum creatinine, genital mycosis, fever, shivering and anaphylactic or anaphylactoid reactions e.g., bronchospasms. **Package and storage:** Ceftriaxone 250 mg I.M. (1 vial + Ampoule of 2 ml solvent). Ceftriaxone 500 mg I.M. (1 vial + Ampoule of 2 ml solvent) Ceftriaxone 500 mg I.V. (1 vial + Ampoule of 5 ml solvent) Ceftriaxone 1 g I.M. (1 vial + Ampoule of 3.5 ml solvent) Ceftriaxone 1 g I.V. (1 vial + 2 Ampoules of 5 ml solvent). Powder for solution for injection/infusion: Store below 25°C. **Reconstituted solution:** Chemical and physical stability has been demonstrated for 24 hours at 2-8°C.

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References:
(1) Data on file. **(2)** Irmeli Roine et al.; Randomized trial of four vs. seven days of ceftriaxone treatment for bacterial me children with rapid initial recovery; Pediatr Infect Dis J, 2000;19:219–22 **(3)** TY Lin et al.; Short-term ceftriaxone therapy fo of severe non typhoidal Salmonella enterocolitis; ACTA Paediatric 92; 537-540 (2003).

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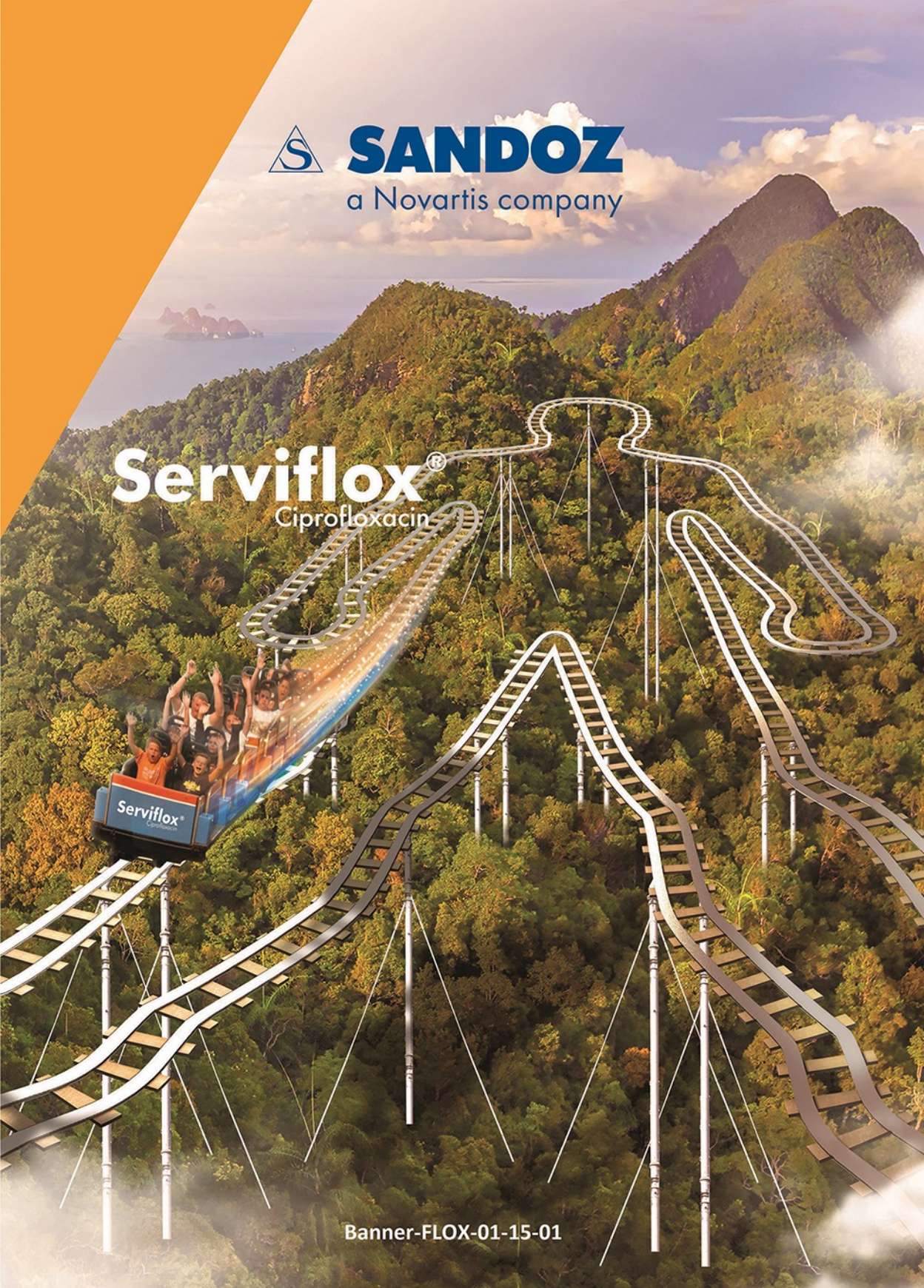
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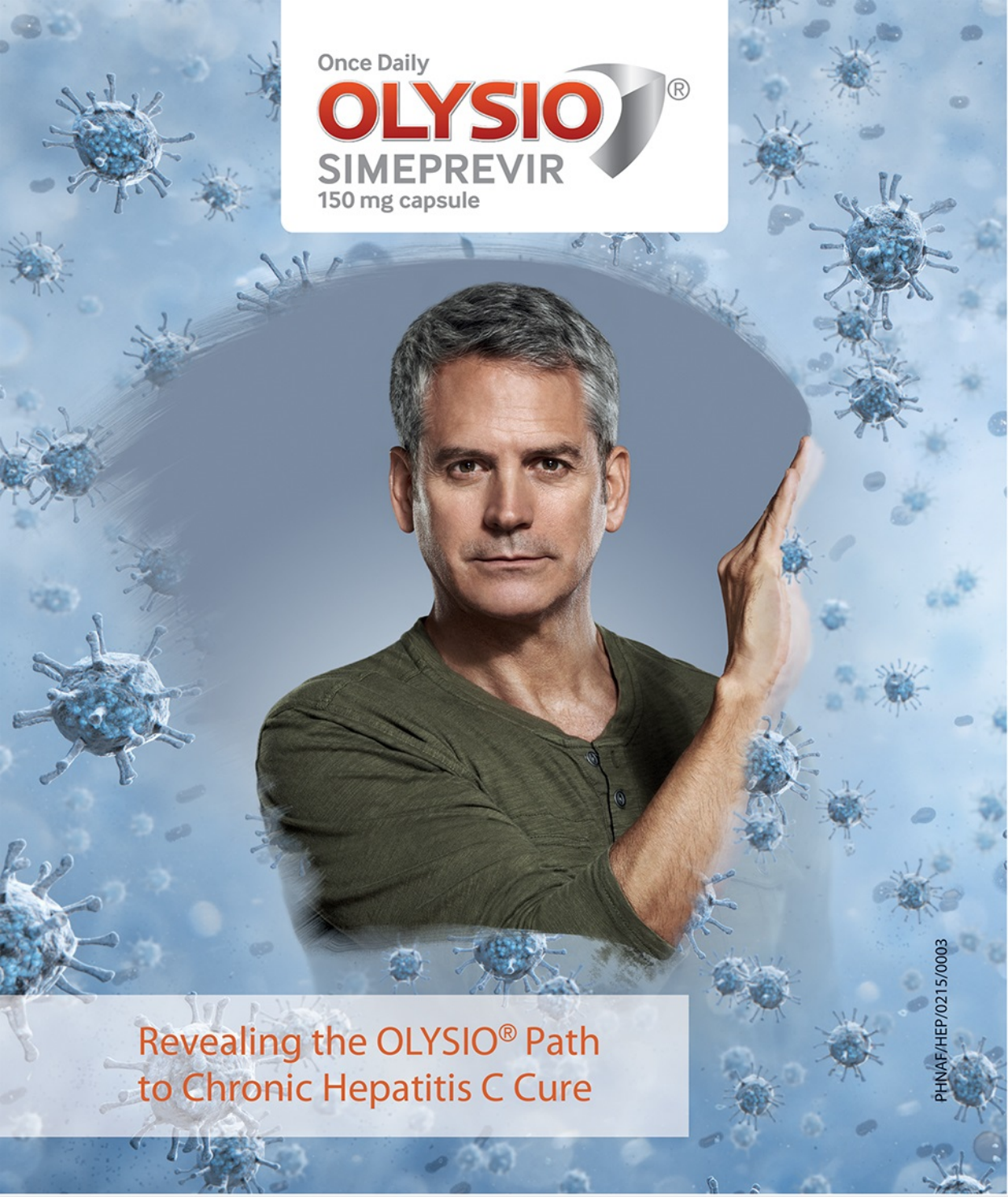

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Composition

.Each film-coated tablet contains 400 mg of sofosbuvir

Therapeutic indications

SOFOSBUVIR-NAPLEX PHARMACEUTICALS is indicated in combination with other medicinal products for the treatment of chronic hepatitis C (CHC) in adults. For hepatitis C virus (HCV) genotype specific activity, see sections "Special warnings and precautions ".for use" and "Pharmacodynamic properties

Posology and method of administration

SOFOSBUVIR-NAPLEX PHARMACEUTICALS treatment should be initiated and monitored by a physician experienced in the management of patients with CHC.

Posology The recommended dose is one 400 mg tablet, taken orally, once daily with food.

SOFOSBUVIR-NAPLEX PHARMACEUTICALS should be used in combination with other medicinal products. Monotherapy of **SOFOSBUVIR-NAPLEX PHARMACEUTICALS** is not recommended. Refer also to the Summary of Product Characteristics of the medicinal products that are used in combination with **SOFOSBUVIR-NAPLEX PHARMACEUTICALS** . The recommended co-administered medicinal product(s) and treatment duration for **SOFOSBUVIR-NAPLEX PHARMACEUTICALS** combination therapy are provided in Table 1.

Table 1: Recommended co-administered medicinal product(s) and treatment duration for SOFOSBUVIR-NAPLEX PHARMACEUTICALS combination therapy

*Patient population	Treatment	Duration
Patients with genotype 1, 4, 5 or 6 CHC	**SOFOSBUVIR-NAPLEX PHARMACEUTICALS**+ ribavirin + peginterferon - alfa	weeks[a,b] 12
	SOFOSBUVIR-NAPLEX PHARMACEUTICALS+ ribavirin Only for use in patients ineligible or intolerant to peginterferon - alfa	weeks 24
Patients with genotype 2 CHC	**SOFOSBUVIR-NAPLEX PHARMACEUTICALS**+ ribavirin	weeks[b] 12
Patients with genotype 3 CHC	**SOFOSBUVIR-NAPLEX PHARMACEUTICALS**+ ribavirin + peginterferon - alfa	weeks[b] 12
	SOFOSBUVIR-NAPLEX PHARMACEUTICALS+ ribavirin	weeks 24
Patients with CHC awaiting liver transplantation	**SOFOSBUVIR-NAPLEX PHARMACEUTICALS**+ ribavirin	Until liver transplantation[c]

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* Includes patients co-infected with human immunodeficiency virus (HIV).

a. For previously treated patients with HCV genotype 1 infection, no data exists with the combination of SOFOSBUVIR-NAPLEX PHARMACEUTICALS , ribavirin and peginterferon- alfa.

b. Consideration should be given to potentially extending the duration of therapy beyond 12 weeks and up to 24 weeks; especially for those subgroups who have one or more factors historically associated with lower response rates to interferon-based therapies (e.g. advanced fibrosis/cirrhosis, high baseline viral concentrations, black race, IL28B non CC genotype, prior null response to peginterferon - alfa and ribavirin therapy).

c. See Special patient populations – Patients awaiting liver transplantation below.

The dose of ribavirin, when used in combination with SOFOSBUVIR-NAPLEX PHARMACEUTICALS , is weight-based (<75 kg = 1,000 mg and ≥75 kg = 1,200 mg) and administered orally in two divided doses with food.

Concerning co-administration with other direct-acting antivirals against HCV, see section "Special warnings and precautions for use

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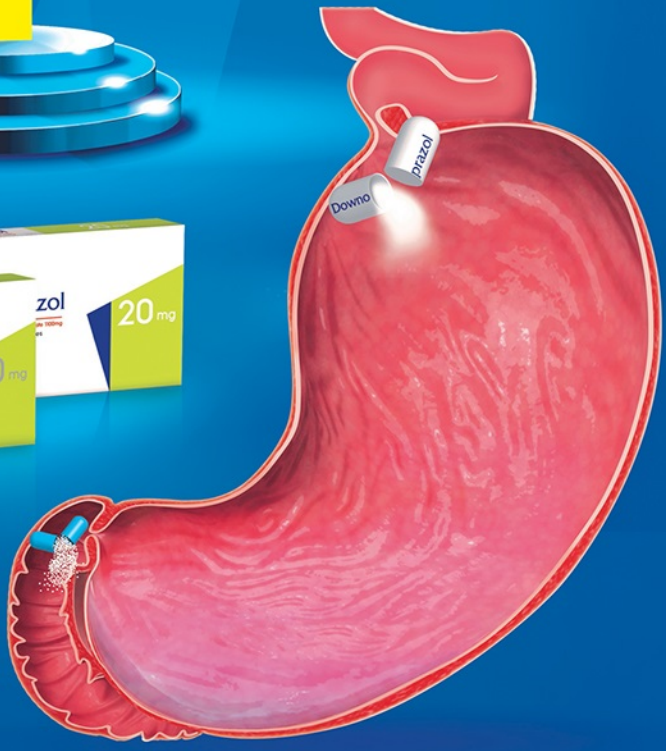

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