11th Global Gastroenterologists Meeting

June 12-13, 2017 Rome, Italy

Scientific Tracks & Abstracts

Day 1

Session

Day 1 June 12, 2017

The Gastroesophageal Reflux Disease: A focus on the situation and therapeutic advances

Session Chair
David H Van Thiel
Advanced Liver and Gastrointestinal Disease Center, USA

Session Co-chair
Antonio Iannetti
University of Rome "La Sapienza", Italy

Session Introduction

Title: **The reflux disease: The situation**
David H Van Thiel, Advanced Liver and Gastrointestinal Disease Center, USA

Title: **Diagnosis: When the pH-impedance and manometry?**
Giuseppe Del Buono, Clinica Pio XI Roma, Italy

Title: **Surgical therapy: A review and technological innovations**
Francesco Falbo, Paolo Urciuoli, University of Rome "La Sapienza", Italy

Title: **The gastroesophageal reflux disease: A focus on endoscopic therapy. A clinical review and scientific literature**
Antonio Iannetti, University of Rome "La Sapienza", Italy

Title: **The GERD-X procedure: Personal casuistry and clinical outcomes**
Rudolph Pointner, Tauernklinikum Zell am See, Austria

David Van Thiel, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Gastroesophageal reflux disease: Recognition, diagnosis, and treatment as seen by a non-esophagologist

David Van Thiel
Advanced Liver and Gastrointestinal Disease Center, USA

Gastroesophageal reflux is a condition that occurs when gastric [gastroesophageal reflux disease (GERD)] or gastroduodenal (EDRD) content refluxes into the esophagus. Depending upon the degree to which duodenal secretions contaminate, the gastric refluxate the refluxed material can be acidic (pH less than 4 for gastric reflux), mildly acidic (pH ranging between 4 but <7, mildly ascitic), or alkaline (pH greater or equal to 7). The patient's symptoms are a reflection of the degree of tissue inflammation plus or minus tissue injury (erosions or ulceration) produced rather than the specific nature of the refluxed material. Continued uncontrolled/chronic reflux leads to the complications of gastroesophageal reflux disease GERD/GDRD consisting of inflammation that can progress to erosions, ulcerations, or scarring (stricture), mucosal metaplasia (Barrett's esophagus) or adenocarcinoma. GERD is a common disorder with world prevalence that somewhat between 10 and 30% of the population being less commonly seen in Asia as compared to Europe or America. Clinical GERD is estimated to be seen in 7% of the population is manifested as heartburn and accounts for 4% of the visits to primary care physicians and is the most common reason for referral to gastroenterologist.

Biography

David Van Thiel is a Gastroenterologist in Berwyn, Illinois. He is affiliated with multiple hospitals in the area, including Rush Oak Park Hospital and Rush University Medical Center. He completed his Medical degree from David Geffen School of Medicine at UCLA and has been in practice for 39 years. He is one of the 21 doctors at Rush Oak Park Hospital and one of 25 doctors at Rush University Medical Center who has specialization in Gastroenterology. He completed his Graduation from University of California at Los Angeles. He has obtained board certification from the member board for Internal Medicine and Hepatology.

dvanthiel@dr.com

Notes:

Giuseppe Del Buono, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Manometry esophageal high resolution and pH-impedenziometry

Giuseppe Del Buono
Clinica Pio XI Roma, Italy

The esophageal manometry is a diagnostic test used in gastroenterology to study esophageal motility. The examination is performed by placing a nasogastric tube into the esophagus of the patient. With esophageal manometry, it is therefore possible to follow the peristaltic wave of the esophagus during swallowing and to verify any motor esophagus (dysphagia abnormalities, achalasia, and diffuse esophageal spasm). The high resolution esophageal manometry, using the latest generation sensors, provides the opportunity to give, at the same time, immediate information of the entire upper digestive tract. The new technology, with the latest classification of Chicago provides a precision and ease than ever before diagnosis. The examination of esophageal manometry high resolution is done through the introduction nasally trans of a catheter with variable number of sensors from 24 to 36 depending on the technology. This allows the complete study of deglutitiva phase maintaining the tube in one location, with the result to obtain: Full results and coordinated activities of the entire deglutitiva; faster execution of the examination; increased compliance examination by the patient. The Ph-metry esophageal 24 hours allows to measure the pH of the esophageal tract for 24 hours, and then determine the number of reflux of acid type had. This examination is carried out by inserting one nostril through a nasogastric tube and placing it into the esophagus. The tube is connected to an instrument, very light and compact, which will record the pH for the entire 24 hours. After placing the tube of pH monitoring, the patient will go home, trying to spend the day in a manner more similar to normal. The examination of pH-metry has some limits: it indicates, in fact, only episodes of reflux of acid type, i.e., if the pH has fallen below the value of 4. Also it cannot determine exactly how high it gets into the esophagus reflux. Symptomatic patients may have a perfectly normal manometry and pH-metry negative! These problems have been overcome by pH-impedance of 24 hours. A nasogastric tube is used on which a pH sensor (two times) is positioned and six channels measure the electrical impedance. The impedance (an electrical resistance) is measured by the instrument and its value varies with the bolus passage. Having six impedance channels on the tube, we cannot discriminate against a swallowing by a reflux and also know how high it's reflux into the esophagus and duration of reflux itself. In addition, since the tube is present as pH sensor, it is also possible to know the degree of acidity of the reflux. The combined pH and impedance measurements have made it possible to classify new categories of reflux: Refluxes acids (pH <4 such as the pH-metry classic examination); refluxes repeated acids while the pH is <4, normally recognized by pH-metry as a single episode of reflux; refluxes mildly acidic with pH> 4 but <7 and; refluxes not with acid pH> 7.

Biography

Giuseppe Del Buono completed his Graduation in Medicine and Surgery in 1981. He is interested in the study of Pathophysiology of the Digestive Tract and Neurogastroenterology. He works with the best specialists in every sector and structure, public and private, to understand and solve a 360° diagnostic and therapeutic issue of gastroenterology. He has to his credit numerous publications and participation at conferences.

giuseppe.delbuono@libero.it

Notes:

Paolo Urciuoli et al., J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Surgical therapy: A review and technological innovations

Paolo Urciuoli, Francesco Falb and **Andrea Biancucci**
Sapienza University of Rome, Italy

American Gastroenterologists Association 2008 Guidelines suggests anti-reflux surgery to be reserved for patients with esophagitis and intolerance to PPI and patients with poor control of the gastro-esophageal reflux symptoms, especially regurgitation. Laparoscopic Nissen-Rossetti fundoplication has become the gold standard, being a well-tolerated operation and considering its good outcome in terms of symptoms relief. In 1939, Rudolph Nissen improvised a fundoplication to protect an esophagogastric anastomosis. Some years later, he performed this procedure to treat gastro-esophageal reflux disease and published the first description of the procedure in 1956. What we now call Nissen-Rossetti fundoplication is the result of the contribution by Nissen's favorite pupil, Marco Rossetti. Nissen-Rossetti fundoplication consists in an extensive mobilization of the posterior wall of the stomach, which enables a loose wrap of the anterior wall to be used for the total wrap, without the division of the short gastric vessels. This procedure showed good results in term of post-operative dysphagia. With the extensive application of laparoscopic surgery during the 1990s, the volume of anti-reflux surgery increased. At the present time, Nissen-Rossetti compare favorably in terms of mortality and morbidity with appendectomy and cholecystectomy. Where is anti-reflux surgery going from now on? Although as of now robot-assisted surgery still has an unacceptable high cost for benign pathology, numerous studies are reporting comparable results in terms of outcomes versus laparoscopic surgery. An interesting new device is LINX©, or Magnetic Sphincter Augmentation (MSA), a small flexible band of interlinked titanium beads with magnetic cores that works by restoring the continence of the lower esophageal sphincter. This device can be easily placed around the gastro-oesophageal junction in about 30 minutes. However, it needs longer follow-up and has some limitation: it can't be used in hiatal hernias larger than 3 cm, the safety and effectiveness of the LINX device has not been evaluated in patients with Barrett's esophagus or grade C or D (LA classification) esophagitis and in patients with electrical implants such as pacemakers and defibrillators, or other metallic, abdominal implants. LNR procedure should be considered the gold standard to treat patient with refractory GERD. REFLUX trial concluded that a surgical policy is probably cost-effective, considering LNR in 5 years follow-up provided a better health-related quality of life compared with medical management. Waiting for a mini-invasive techniques standardization and long term follow up, patients should be aware of the safeness and feasibility of laparoscopic Nissen-Rossetti fundoplication.

Biography

Paolo Urciuoli completed his Graduation at University of Rome "La Sapienza" in 1984. In November 1984, he passed the state examination for the qualification to the profession of Surgeon Doctor at University of Rome "La Sapienza". In 1989, he specialized in General Surgery. In 2000, he specialized in Vascular Surgery. He completed his internship in Surgery General and Colo-proctology at Thomas Jefferson University in Philadelphia, USA. Since 1990, he is a Researcher at Institute of Surgical Clinic III (currently Department of Surgical Sciences).

purciuoli@gmail.com

Notes:

Antonio Iannetti, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

The management of gastroesophageal reflux disease: Medical, surgical and endoscopic therapy; a clinical review and scientific literature

Antonio Iannetti[1, 2]
[1]Policlinico Umberto I, Italy
[2]Sapienza University of Rome, Italy

Introduction: The incidence of gastroesophageal reflux disease in the population of industrialized countries is high and ranges from 20 to 40% in the age groups between 45-64 years, with a further increase in the incidence in the age between 64-74 years. The natural history of the disease requires continuous recrudescence alternated with quiescent phases. In view of these epidemiological data, importance of the social problem and the high health costs is cleared. It follows the interest of pharmaceutical companies, the companies of electromedical and producing toolkits endoscopic and surgical companies.

Objective: In this session, I intend, with the participation of colleagues internists and surgeons, to make a brief stock of the situation, about the gastro-esophageal reflux disease. I will make a tour of the clinical presentation, the increase of incidence, especially of so-called atypical forms and symptoms of gastro-pharingeal reflux (high reflux), emphasizing how many patients are refractory to therapy. Patients who benefit from medical treatment, they become dependent on care. Whereas, many are young and that medical therapy has adverse side effects, such as anemia, osteoporosis, and infections, is the need for alternative therapies. Physiotherapy global posture, for example, can be a transient and partial support. The ultimate solution is or should be surgical.

Considerations: Surgical therapy makes use of minimally invasive or laparoscopic method, which shortens the hospital stay. But an endoscopic surgery, easy, repeatable, free from postoperative complications, can be performed in day surgery, would be ideal for this type of chronic disease. In reviewing the different techniques, that have been proposed over the last 20 years, I relate the considerations, derived from the international literature. This presentation is concluded by presenting a last device, manufactured in Germany, derived from its precursor, the NDO Plicator, which is making use of the addition of heads polytetrafluoroethylene (PTFE), which retain the suture threads from the traction, exerted by the tissues, seem to improve the seal in time.

Conclusions: I carry scientific studies that have compared the operations, performed with GERD-X Plicator, to surgical interventions of fundoplication, with satisfactory results. My invitation is to continue to seek solutions with endoscopic surgery, which is the most appropriate technique for this type of pathology.

Biography

Antonio Iannetti has completed his Degree in Medicine and Surgery and Specialties in Gastroenterology and Internal Medicine at University of Rome. He is interested in "Endoscopic sclerosis of esophageal varices and retrograde cholangiopancreatography-endoscopically". He is a Professor and Chair of Gastroenterology at University of Rome. He is Head of the Digestive Endoscopy Service of University Hospital Umberto I in Rome. He is an Expert of the Ministry of Health for Gastroenterology.

antonio@iannetti.it

Notes:

Rudolph Pointner, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

The GERD-X procedure personal casuistry and clinical outcomes

Rudolph Pointner
Tauernklinikum Zell am See, Austria

Introduction: The GERD-X procedure is a further development of the NDO-Plicator-system consisting of a flexible endoscope-like tube and a playstation-like operating console. In the front of the tube the needles and pretied sutures are hold in a closed snake- or crocodile-like mouth. The procedure is performed under direct vision of a retroflexed baby scope, which is passed through the inserted tube in a patient under general anaesthesia in normal back position. Once in appropriate position at the left side of the GE-junction the arms of the device are closed, deploying the implant which is made of pretied sutures and PTFE-blades. Subsequently after realizing this first step, the device is removed, leaving a full thickness permanent suture plication of the gastric wall. This procedure is reproducible until the GE-junction is tight and shows a fundoplication-like gastroesophageal valve Hill Grade I.

Aim: Aim of this presentation is to present a series of 120 patients assigned to the GERD-X procedure. In all those patients, a meticulous preoperative examination was performed, including endoscopic examination, cinematographic esophageal barium X-ray-studies, high resolution manometry, impedance pH-monitoring and quality of life score studies using the gastrointestinal quality of life-score according to Eypasch and Troidl. Exclusion criteria for performing the GERD-X-procedure in this series were defined as hiatal hernias more than 1 centimeter detected in high resolution manometry and/or a gastroesophageal valve more than Hill Grade II.

Considerations: According to a detailed follow-up and analysis of our patients, the focus for achieving good results has to be put on the exclusion criteria of a Hiatal hernia or gastroesophageal valve more than Hill Grade II and a sophisticated handling of the GERD-X device. Meeting these presumptions excellent results corresponding to the GIQLI-score can be achieved, although the number of reflux episodes decreases only to the middle compared to a decrease of about 90% after a Nissen procedure.

Conclusion: The special merits of the GERD-X procedure are a high rate of patient satisfaction according to the GIQLI scores without producing complications or side effects as they are known after laparoscopic fundoplication.

Biography

Rudolph Pointner is currently working at Tauernklinikum Zell am See, Austria. He has published research papers and articles in reputed journals and has various other achievements in the related studies. He has extended his valuable service towards the scientific community with his extensive research work.

rudolph.pointner@kh-zellamsee.at

Notes:

Sessions

New Therapeutic Possibilities in Digestive Endoscopy with Particular Reference to the Problem of Obesity and Metabolic Syndrome: An International Review | Gastroenterology/ Surgery/ Cancer

Session Chair
Antonio Iannetti
University of Rome "La Sapienza", Italy

Session Chair
Kenji Sasaki
Home Medical Care Supporting Clinic Sendai, Japan

Session Co-chair
Andrea Formiga
Istituti Clinici Zucchi Monza, Italy

Session Co-chair
Rudolph Pointner
Tauernklinikum Zell am See, Austria

Session Introduction

Title: **Endoscopic therapy of obesity**
Alfredo Genco, Sapienza University, Itlay

Title: **Abstract Endobarrier System, Duodenal Jejunal Endoscopic linear bypass**
Andrea Formiga, Istituti Clinici Zucchi Monza, Italy

Title: **Duodenal Gastrinoma Associated with Multiple Endocrine Neoplasia Type 1 (MEN1) Detected by Esophagogastroduodenoscopy (EGD), Which Was Buried under Ulcer**
Kenji Sasaki, Home Medical Care Supporting Clinic Sendai, Japan

Title: **Sofosbuvir plus daclatasvir treatment for patients with chronic hepatitis C genotype 3 infection with or without cirrhosis**
Omesh Goyal, D.M.C. and Hospital, India

Title: **Gastrointestinal Dysfunction in Postural Tachycardia Syndrome**
Anna DePold Hohler, Boston University, USA

Title: **Can argon plasma coagulation be endoscopic recovery treatment in uncontrolled esophageal varices bleeding?**
Huseyin Sancar BOZKURT, Medical Park Private Tarsus Hospital, Turkey

Title: **Molecular epidemiological study of Norovirus related outbreak in Korea**
Deog-Yong Lee, National Institute of Health, KCDC, Korea

Title: **It's all in your gut - novel links between gut hormones and obesity, metabolic diseases, inflammation, malignancies and reproductive system**
Nevena Ilic, Euromedik General Hospital, Serbia

Title: **Better Outcome in Laparoscopic Gastric Ulcer Perforation than Laparotomy: Single Center Experience**
Andriana Purnama, Padjadjaran University, Indonesia

Title: **Cancer metastasis biomarkers: Discover, develop, intervene**
Ulrike Stein, Max Delbruck Center for Molecular Medicine, Germany

Title: **Complications in Esophageal Surgery**
Dmitriy Shamrai, National Cancer Institute, Ukraine

Title: **Best fluid management for bariatric surgery: Restrictive or Liberal**
Baris Cankaya, Marmara University, Turkey

Andrea Formiga, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Endobarrier system: Duodenal jejunal endoscopic linear bypass

Andrea Formiga
Istituti Clinici Zucchi Monza, Italy

Introduction: The Endobarrier system is an innovative reversible endoscopic system indicated for the treatment of diabetes mellitus type II and obesity. The duration of treatment is one year. The process involves a decrease in glycated hemoglobin of two points in the year of treatment with reduction and/or elimination of oral hypoglycemic agents and/or units of insulin administered daily, improved lipid profile and liver function tests, reduction of blood pressure, and weight loss of about 40% of excess body weight. The system is totally endoscopic, simulates the effect obtained with a laparoscopic gastric bypass but without making sections and/or removal organ.

Method: From March 2014 to November 2016, we performed 20 placements of Endobarrier system (15 men, 5 women), of whom 16 successfully concluded and extracts, four still in progress; two system extractions of foreign patients who had undergone placement in other countries (Australia, South Arabia), one missed positioning for non-compliant patient anatomy (inability to access the capsule in the duodenal bulb). The average hospital stay of patients was one day. The mean age of patients was 46 (24-63 aa) years. All positioning and extraction operations were performed under general anesthesia.

Results: The mean preoperative BMI was 45.8, average BMI 37.8 postoperatively; preoperative Hb A1c 8.9/postoperative HbA1c 6.6; PA values systolic/diastolic mean preoperative 134/85.7 and; PA values postoperative systolic/diastolic 124.7/71.8.

Complications: We found the appearance of a duodenal ulcer bleeding in the vicinity of the metal anchoring system that was treated with medical drugs and with the removal of the system; in the same patient appearance of mild pancreatitis with high levels of amylase (400) and lipase (200) resolved spontaneously after removal. One hepatic abscess in a foreign patient came to our attention from other structure to which it was addressed in urgency.

Conclusions: The endoscopic endoluminal treatments are now having great expansion and interest even in the treatment of morbid obesity and diabetes. The Endobarrier system is an innovative totally endoscopic malabsorptive reversible treatment that can have an important role in the treatment of diabetes mellitus type II and obesity. Our experience has shown the effectiveness and feasibility of Endobarrier system. It remains to evaluate the results in the time after removal.

Biography

Andrea Formiga has completed his PhD at Milan University Italy. In 2002, he has completed Post-doctoral Specialty in General Surgery. He is the Director of General Surgery at Istituti Clinici Zucchi Spa – Monza, Italy. He is a member of International Advisory Board for Apollo Endosurgery. He has published many documents in surgical and endoscopic treatments for general surgery and obesity procedures. He has participated at many national and international congresses.

a.formiga1971@gmail.com

Notes:

Kenji Sasaki, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Duodenal gastrinoma associated with multiple endocrine neoplasia type 1 detected by esophagogastroduodenoscopy which was buried under ulcer

Kenji Sasaki
Home Medical Care Supporting Clinic Sendai, Japan

A 66-year-old Japanese male was shown to have severe ulcers with hypergastrinemia in the stomach through proximal horizontal part of the duodenum. He suffered from gastric ulcer at 63 and hyperparathyroidism at his 5th decade. Though he had no definitely enlarged pituitary detectable by computed tomography, he had slight defects in the visual field and hyperprolactinemia. A diagnosis of multiple endocrine neoplasia type 1 (MEN1) was entertained. Follow up EGD revealed five small sessile submucosal tumors (SMTs) with a central depression or erosion in the duodenal bulb through descending part of the duodenum, which had been obscured beneath ulcers. Demonstrated in the regenerative mucosa by biopsy were clusters of small tumor cells, which, though considered the tips of neuroendocrine (NE) tumor (NET) in the deeper layer, were not large enough to be proven so by immuno staining with the markers in the serial sections, and diffuse hyperplasia of synaptophysin-, chromogranin A- and gastrin-positive NE cells in brunner glands (BGs), the preneoplastic lesion characteristic of MEN1-associated duodenal gastrinoma, supporting the diagnosis, which was firmly guaranteed by positively elevated glucagon-provoked plasma gastrin. Subtotal stomach-preserving pancreaticoduodenectomy established the final diagnosis of duodenal gastrinoma graded G1 associated with MEN1, which were shown to be tightly contained in the densely conglomerated hyperplastic BGs. Difficulty in endoscopically detecting the NET lies in the fact that, in addition to its smallness and deep localization, it might be buried under peptic ulcer at a certain stage and that an attempt to biopsy it is hampered by the densely conglomerated hyperplastic BGs in some cases.

Biography

Kenji Sasaki completed his MD and, as an Immunologist, he completed his PhD at Tohoku University School of Medicine. He was trained at Miyagi Cancer Center. He is a Board Certified Fellow and Preceptor of Japan Gastroenterological Endoscopy Society, Board Certified Gastroenterologist of Japanese Society of Gastroenterology, Board Certified Member of the Japanese Society of Internal Medicine and Editorial Board Member of CRIM. He has published several papers on Gastroenterology in international journals and served as a Reviewer for *Journal of Medical Microbiology, Journal of Pharmacology & Pharmacotherapeutics* and *Journal of Gastrointestinal & Digestive System.*

kydosarnymai@aria.ocn.ne.jp

Notes:

Omesh Goyal et al., J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Sofosbuvir plus daclatasvir treatment for patients with chronic hepatitis C genotype 3 infection with or without cirrhosis

Omesh Goyal, Ajesh Bansal and **Rajoo Singh Chhina**
D.M.C. and Hospital, Ludhiana, India

Statement of the Problem: In treatment-naïve patients with chronic hepatitis C(CHC) genotype 3(G-3) infection without cirrhosis, sofosbuvir plus daclatasvir daily for 12 weeks is the recommended therapy. In patients of CHC-G3 with cirrhosis, it is recommended to add daily ribavirin for 24 weeks along with the above combination, as data regarding the optimal duration of therapy in this subgroup is scarce. We aimed to study the SVR rates in CHC G3 patients with or without cirrhosis treated with sofosbuvir and daclatasvir. Methodology & Theoretical Orientation: Total 192 treatment naïve CHC-G3 patients treated with sofosbuvir and daclatasvir were enrolled. Of these, 112 did not have cirrhosis (group I), 42 had compensated cirrhosis (Child-Pugh A) (group II) and 32 patients had decompensated cirrhosis (Child Pugh B/C) (group III). Group I was treated with daily sofosbuvir(400 mg) and daily daclatasvir(60 mg) for 12 weeks, group II with daily sofosbuvir, daclatasvir and ribavirin(1000 or 1200 mg; weight based) for 12 weeks, and group III with sofosbuvir, daclatasvir and ribavirin for 24 weeks. HCV RNA was repeated at 12 weeks post-therapy for sustained virological response (SVR). Findings: Baseline characteristics in the three groups were similar (median age 48 years, 78% males). SVR rates in three groups are shown in figure. The SVR rate of group II was similar to group I ($p< 0.0001$). The SVR rate of group III was also similar to that of group II ($p< 0.0001$). No major adverse events were reported. On multivariate analysis, presence of decompensated cirrhosis was the only factor associated with relapse. Conclusion & Significance: This is the first study to show that patients of CHC G3 infection with compensated cirrhosis can achieve excellent SVR rate when treated with sofosbuvir, daclatasvir and ribavirin for 12 weeks. Patients with decompensated cirrhosis require triple therapy for 24 weeks.

Figure: Flow chart showing the three treatment groups and the treatment response

Biography

Omesh Goyal is working as an Associate Professor in Gastroenterology and Hepatology in a tertiary care institute in northern India. He has done lot of research work on chronic hepatitis C and complications of cirrhosis. His other major interest includes functional bowel disorders and ano-rectal manometry. He is a part of the Indian working group on Chronic Constipation which will formulate guidelines for constipation in India under the leadership of Dr Uday Ghoshal. His research work in has been acclaimed at international level. He won the National Scholar Award at UEG in Sweden and Best paper award in APICON in Hyderabad, India. He is working as an editor of the Journal of Gastrointestinal Infections and is an active member of various academic bodies.

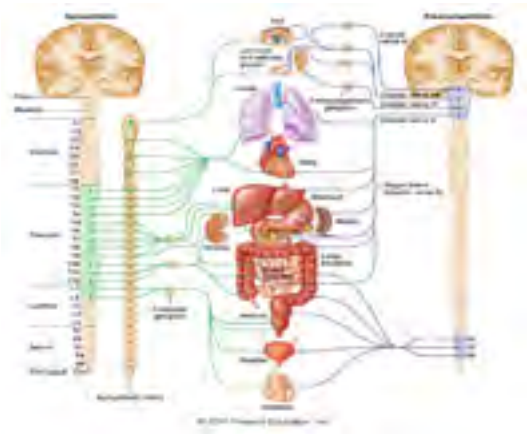
goyalomesh@yahoo.co.in

Anna DePold Hohler, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Gastrointestinal dysfunction in Postural Tachycardia Syndrome (POTS)

Anna DePold Hohler
Boston University School of Medicine, USA

Postural Tachycardia Syndrome (POTS) is associated with a number of systemic effects including gastrointestinal (GI) dysfunction. The most commonly reported GI symptoms are nausea, irregular bowel movements, abdominal pain, and constipation. Many POTS patients report GI symptoms more than once per week. They often require a GI specialist. The POTS patients often have gastroparesis or delayed gastric emptying. GI disturbances are frequent and prolonged in patients with POTS, impacting quality of life. Given the importance of the enteric nervous system to normal GI functioning, the same autonomic impairment leading to POTS may result in abnormal gut motility and ultimately subjective GI discomfort. Treatment of autonomic dysfunction in POTS and dietary changes may improve GI dysfunction associated with POTS.



Biography

Anna DePold Hohler is an Associate Professor of Neurology at Boston University School of Medicine. Her research interests include "Autonomic research in Parkinson's disease and postural tachycardia syndrome". She has described the genetic association between POTS and Ehlers Danlos type III. Recently, she has explored gastrointestinal, sleep, and dermatologic disorders. She has numerous publications and is an expert and frequent Reviewer. She has dozens of publications and serves as an Associate Editor of *Continuum*, one of the premier neurology journals. She is the recipient of numerous awards, including army achievement and commendation medals and two meritorious service medals for excellence in clinical and teaching skills while serving on active duty. She also received BUSM's prestigious Stanley L. Robbins Award for Excellence in Teaching and several Neurology teaching awards, including two from the American Academy of Neurology (AAN). She co-chairs the AAN Quality Safety Subcommittee.

anna.hohler@bmc.org

Notes:

Huseyin Sancar Bozkurt, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Can argon plasma coagulation be endoscopic recovery treatment in uncontrolled esophageal varices bleeding?

Huseyin Sancar Bozkurt
Medical Park Tarsus Hospital, Turkey

Statement of the Problem: Esophageal variceal bleeding is a life-threatening complication of portal hypertension with a six-week mortality rate of approximately 20%. The available data suggest that vasoactive drugs, combined with endoscopic therapy and antibiotics, are the best treatment strategy with endoscopic variceal ligation (EVL) being the endoscopic procedure of choice. Tissue adhesives, endoloops, endoscopic clipping and argon plasma coagulation (APC), have been used in the management of uncontrolled esophageal varices bleeding.

Case Report: We reported two cases 77-year-old man with hepatitis C, Child-Pugh B cirrhosis who received EVL for esophageal variceal haemorrhage two years ago and 47-year old man with alcohol induced Child-Pugh C cirrhosis who received EVL for esophageal variceal haemorrhage one year ago included with uncontrolled esophageal varices bleeding.

Results: Argon plasma coagulation has been used as a recovery treatment for controlling of acute esophageal varices bleeding after unsuccessful endoscopic sclerotherapy and EVL (figure 1 and figure 2). The bleeding was controlled successfully in patients.

Conclusion: To our knowledge, this is the first documented case to report APC used in uncontrolled acute esophageal varices bleeding. Argon plasma coagulation can be endoscopic recovery treatment in uncontrolled esophageal varices bleeding.

Figure 1: Acute esophageal varices bleeding

Figure 2: Bleeding was controlled after APC

Biography

Huseyin Sancar Bozkurt has completed his PhD at the age of 24 years from Trakya University and İnternal Medicine at the age of 30 from Çukurova University. He has completed gastroenterology education at the age of 33 years from Adana Baskent University. He has published multiple national and international papers.

sancarb79@gmail.com

Notes:

Deog-Yong Lee, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Molecular epidemiological study of Norovirus related outbreak in Korea

Deog-Yong Lee
Korea National Institute of Health, South Korea

Viral gastroenteritis was generally induced in a child less than 5 year old by type A rotavirus, enteric adenovirus, astrovirus, *Sapovirus*, except for norovirus. These were designated as surveillance required pathogens legally and this was performed by KNIH (Korea National Institute of Health) as a name of EnterNet-Korea. In this point, we analyzed genotype of enteric virus in Korea to investigate evasion of host immune system. Norovirus is typical single-stranded (+) RNA virus and is divided into 5-genogroup. Genogroup I and II generally infect human. Norovirus GII.4 was main genotype in the world. GII.4 strain continuously mutated their genome and several GII.4 variants induced outbreaks, like as Sydney variant associated outbreak. In recent, GII.17 is emerging genotype in south-east Asia and induced several outbreaks last winter seasons. This is the huge antigenic change of norovirus in south-east Asia and it may spread to other area. Recently, the genotype of other virus also changed and sometimes induced outbreak by minor genotypes in Korea. Genotypes provide important information about evading strategy of enteric virus from host immune system and this also provides tactical information to diagnose and prevent pathogens. Although we are not able to catch up the mutation rate of enteric virus, we must continuously follow up to decrease disease.

Biography

Deog-Yong Lee has completed his Doctor of Veterinary Medicine (DVM) and PhD at Seoul National University. He is a Staff Scientist and team leader of enteric virus team in Division of Enteric Disease, KCDC. He has published more than 100 papers in reputed journals.

Leedy0610@korea.kr

Notes:

Nevena Ilic, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

It's all in your gut - novel links between gut hormones and obesity, metabolic diseases, inflammation, malignancies and reproductive system

Nevena Ilic
Euromedik General Hospital, Belgrade, Serbia

The gastrointestinal tract is an organ essential for the digestion and extraction of nutrients, but it's also body's largest endocrine organ. First discovered hormones at the beginning of the 20th century were gastrin, secretin and cholecystokinin. Now, we discuss about more than 30 different regulatory peptide hormones and more than 10 types of endocrine cells found in stomach, small and large intestines, such as incretins (glucose-dependent insulinotropic peptide and glucagon-like peptide-1), peptide YY, oxyntomodulin, ghrelin, obestatin and others. The role of gut hormones in energy homeostasis has been studied over the past 20 years. A great deal of researches in last years had shown the relationship between gastrointestinal hormones, obesity and type 2 diabetes, starting with incretin concept. Now, we have therapies based on gut hormones as targets, for patients with obesity, diabetes and non alcoholic fatty liver. Latest data present gut peptides as novel regulators of intestinal lipoprotein secretion and thus may have a great role in cardiovascular risk. Studies confirmed that gut hormones play a critical role in the regulation of metabolic, water and salt homeostasis and the development of hypertension and cardiovascular diseases. Recent investigations explained molecular mechanisms connecting gut hormones, insulin resistance and malignancies as well as inflammation processes in organism. Gut-brain axis and metabolism in polycystic ovary syndrome and it's treatment has been a subject of polemics on recent endocrinology debates. Finally, there is a link between gut, adipose hormones and reproductive system and fertility in both sexes.

Biography

Nevena Ilic has completed her MhD in Endocrinology at Belgrade University Medical School in 2009 and Master's degree in Thyroid Diseases in Italy, 2014. She completed Internal Medicine Specialisation at Military Medical Academy Hospital, Belgrade in 2002. From 2014, she works as Prime Endocrinologist at Euromedik General Hospital, Belgrade, where she organized endocrinology service and several symposiums in Belgrade and Rome, where she was a speaker. She spoke at several international congresses. She has published three papers in reputed journals as a first autor and many papers as the one of co-autors. She is a member of European and Italian Endocrinology Society.

nevenanella@gmail.com

Notes:

Purnama Andriana et al., J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Better outcome in laparoscopic gastric ulcer perforation than laparotomy: Single center experience

Purnama Andriana and **Rudiman Reno**
Hasan Sadikin General Hospital, Indonesia

Perforated gastric ulcer is still the most common indication for emergency gastric surgery associated with high morbidity and mortality. Outcome might be improved by performing laparoscopy. The aim of this study was to evaluate the outcome of laparoscopy at Hasan Sadikin Hospital. The outcome laparoscopy approach and the associated morbidity and mortality, operation time, conversion rate and hospital stay were assessed and compared with laparotomy. There were 30 patients (24 males, 6 females) with perforated gastric ulcer with mean age 72.14, non-malignant cause was documented during January 2015-Desember 2015. Patients with Boey's score 0-1, ulcer diameter less than 2 cm at anterior site, underwent laparoscopic gastric perforation closure with omental patch and the rest were laparotomy. Observation from 15 patients underwent laparoscopy with no conversion, resulted in a better outcome from duration of operation 60-90 minutes (mean 79.57) than laparotomy 60-120 minutes (mean 85.73). Postoperative pain was found better outcome in laparoscopy VAS 3.93, laparotomy 6.27. Early diet was implemented in laparoscopy patients according to ERAS from POD one. Length of hospital stay in laparoscopy group was five days and 10-12 days (mean 10.5) in laparotomy. Incidence of surgical site infection was found in five patients, leakage from perforated site in six patients and mortality in six patients, all of them were found in laparotomy group. Laparoscopy closure of perforated gastric ulcer is a safe therapeutic method with strict selection of patient criteria. Based on low rates of morbidity and mortality, we should encourage laparoscopy implementation in gastric ulcer perforation case.

Biography

Purnama Andriana has completed his Digestive Surgeon education at Hasan Sadikin Hospital, Padjadjaran University, Indonesia. He attended many digestive surgery courses and fellowships, including Laparoscopic Colorectal Fellowship at Singapore General Hospital (2009), Minimal Invasive Surgery training at Academisch Medisch Centrum Amsterdam (2012) and, Endoscopy Laparoscopy training at Queen Mary Hospital, Hong Kong (2013). He has become Digestive and General Surgery Consultant Staff at Padjadjaran University, Indonesia.

apuyboy@yahoo.com

Notes:

Ulrike Stein, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Cancer metastasis biomarkers: Discover, develop and intervene

Ulrike Stein[1, 2]
[1]Charité – Universitätsmedizin, Germany
[2]Max Delbruck Center for Molecular Medicine, Germany

Statement of the Problem: Metastasis is directly linked to colorectal cancer (CRC) patient survival and accounts for about 90% of patient deaths. It represents the most lethal event during the disease course and critically limits successful therapy.

Aim: Our translational concepts aim at the identification of key molecules such as S100A4 in tumor progression and metastasis for improved prognosis and therapy of solid cancers.

Methodology: We discovered key players of metastasis, their transcriptional targets, protein binding partners and signaling pathways thereof as new diagnostic, prognostic and predictive biomarkers for tumor progression and metastasis. Biomarker development was done in established and patient-derived 3D cultures, cell line-derived and patient-derived xenografts (PDX) and newly generated genetically engineered mouse models. We exploited this knowledge for improved disease prognosis and treatment response prediction in tissue and blood of cancer patients of several tumor entities. We established intervention strategies targeting biomarkers such as S100A4 for metastasis inhibition in mice.

Results: Small hairpin RNA (shRNA) acting on the biomarkers, on their transcriptional or post-translational targets decreased *in vivo* metastasis, also when applied systemically. In particular, small molecule transcriptional inhibitors were identified by high throughput screening, restricted biomarker-induced metastasis in mice. This repositioning of already FDA-approved drugs for the new indication of metastasis restriction paved the way for clinical trials.

Conclusion & Significance: We currently translate our findings on restricting S100A4-driven colorectal cancer metastasis into clinical practice. Novel therapeutic approaches targeting S100A4 are currently tested in phase II clinical trials to treat patients with metastatic disease. Our assay for detecting and quantifying circulating biomarker transcripts in patient blood is used to monitor treatment success.

Biography

Ulrike Stein completed her Diploma degree at Martin-Luther University Halle, Germany and PhD at Humboldt University Berlin. For her Post-doctoral studies, she joined the laboratory of Dr. R H Shoemaker at National Cancer Institute/NIH Frederick as Feodor-Lynen-Fellow of Alexander von Humboldt foundation. She received her Habilitation at Charité Universitätsmedizin Berlin and appointed as Professor. She heads the research group of Translational Oncology of Solid Tumors at Experimental and Clinical Research Center, Charité Universitätsmedizin and Max Delbruck Center for Molecular Medicine in Berlin. Her research is focused on "Understanding and intervening in tumor progression and cancer metastasis formation". She has published more than 130 papers in reputed journals. She is an Editorial Board Member and Reviewer of several journals. She received various national and international scientific awards.

ustein@mdc-berlin.de

Notes:

Dmitriy Shamrai et al., J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Complications in esophageal surgery

Dmitriy Shamrai and **Kondratskyy Y**
National Cancer Institute, Ukraine

Background & Aim: Despite esophagectomy is common surgical procedure, high complication rate, their early detection and management remains challenging problem. The aim of the study is to find out complications in esophageal surgery.

Methods: We reviewed medical documentation of patients who underwent esophagectomy at National Cancer Institute (Kiev, Ukraine) between January 2010 and December 2016. Esophagectomies were done in Lewis, McKeown and transhiatal manner. We performed three field dissections in patients with upper third tumors of the esophagus with clinical lymph node metastases in the superior mediastinum; the others underwent two field dissection. All esophagectomies were done by one team of surgeons. We analyzed complications according to Clavien-Dindo classification and role of early endoscopy in prediction of anastomotic problems.

Results: 300 patients with esophageal cancer were operated: 285 Lewis, 12 McKeown and three transhiatal esophagectomies. Postoperative complication rate was 24.3% (73 cases), perioperative mortality rate–3% (nine patients). Surgical complications grade I-II took place in 23 patients, grade III–27 cases; grade IV 23 cases (according to Clavien-Dindo classification). The most frequent complications were pneumonia (n=14) and pleural effusion (n=9). Recurrent laryngeal nerve palsy developed only in one patient. We divided life-threatening complications (grade IV) into surgical (anastomotic leak n=7, empyema n=4, mediastinitis n=3) and non-surgical groups (pulmonary embolism n=7, myocardial infarction n=3). All symptomatic anastomotic leaks (n=7) were operated and anastomotic structures (n=4) were stented. Early endoscopy (within 1 week after operation) was done in 156 patients. It helped to predict anastomotic problems in six cases (true positive results).

Conclusion: Despite non-surgical complications led to death more frequently, they were always accompanied by surgical complications. To minimize anastomotic leaks rate, surgical technique and surgeon's experience (more than 40 esophagectomies every year) is crucial. Early endoscopy can predict anastomotic problems and would be investigated further.

Biography

Dmitriy Shamrai is working at National Cancer Institute, Ukraine. He is the recipient of numerous awards for his expert research works in related fields. His research interests reflect in his wide range of publications in various national and international journals.

shamraydv@gmail.com

Notes:

Baris Cankaya, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Best fluid management for bariatric surgery: Restrictive or liberal

Baris Cankaya
Marmara University, Turkey

Bariatric and metabolic surgery procedures are choice of treatment with an increasing number worldwide. Fluid management is a topic of debate for many years. Restrictive and liberal fluid protocols are under research of clinical trials. Which fluid regime should be the best for bariatric procedures? A low fluid administration may lead to decreased circulating volume, redistribution of plasma, decreased urine output. On the other hand, fluid overload may cause complications as edema, raised central venous pressure, deformation of glycocalyx. There is intestinal edema can lead to impaired tolerance for enteral nutrition. Randomized 48 American Society of Anesthesiologists (ASA) grade 1–3 patients for cholecystectomy operation have been compared with liberal (40 ml/kg) and restricted (15 ml/kg) fluid regime. It has been reported that those receiving liberal therapy had fewer postoperative complications. For a long time, it has been accepted that liberal perioperative intravenous fluid administration was better. There are now more evidence that restricted regimen would be more suitable for fast track colon surgery. Major abdominal surgery has risks, economic results and postoperative complications. Latest RELIEF trial (restrictive versus liberal fluid therapy in major abdominal surgery) has found out preliminary supportive evidence for restrictive regimen for major abdominal surgery. As a conclusion perioperative fluid regimen should be individualized. Fluid regimen plays an important role on hospital length of stay for patients undergoing laparoscopic bariatric surgery.

Biography

Baris Cankaya completed his Graduation at Ankara University Medical Faculty in 2000. He has been working as Anaesthesiology Specialist at Marmara University Training Hospital. He has attended academic meetings, nationally and internationally. His academic interest includes “Microcirculation, fluid therapy, resuscitation, patient safety and perioperative analgesia”. Some of his certificates are: EPLS provider Berlin 2015, NLS provider Athens 2015 and MECOR Level I October 2014. He attended international workshops like ECMO workshop 2015, Leicester and Airway workshop, ICISA 2014, and Tel Aviv.

cankayabaris@hotmail.com

Notes:

11th Global Gastroenterologists Meeting

June 12-13, 2017 Rome, Italy

Scientific Tracks & Abstracts

Day 2

Hepatobiliary | IBD/ Endoscopy

Session Chair
David H Van Thiel
Advanced Liver and Gastrointestinal Disease Center, USA

Session Co-chair
Errawan R Wiradisuria
Indonesian Society of Endo-Laparoscopic Surgeons (ISES), Indonesia

Session Introduction

Title: **Non-invasive assessment of liver fibrosis and steatosis**
Wai-Kay Seto, The University of Hong Kong, Hong Kong

Title: **Current safety and feasibility of ERCP in management of early and late post liver transplant biliary complications**
Esam Elshimi, National Liver Institute, Menoufiya University, Egypt

Title: **Recent Advances In Cbd Stones Management, Laparoscopic Common Bile Duct Exploration (LCBDE)**
Errawan R Wiradisuria, Indonesian Society of Endo-Laparoscopic Surgeons (ISES), Indonesia

Title: **Acute pancreatitis cases in Turkey: A review of the literature between 1980 and 2016**
Bulent Calik, University Izmir Tepecik Education and Research Hospital, Turkey

Title: **Complications of Antegradny Access at the Decompression of Bilious Channels at Patients with Mechanical Jaundice and Ways of their Treatment**
Liana Kurmanseitova, Stavropol State Medical University, Russia

Title: **Ulcerative Colitis (UC) - Associated Colorectal Cancer (CRC) Patients Who Receives Colorectal Surgery More Likely Receive Blood Transfusion and Parental Nutrition Than Crohn's Disease (CD) - Associated CRC Patients - A Propensity Match Study**
Cheng Zhang, The Ohio State University, USA

Title: **Colonoscopy and Infectious Disease**
Sebnem Calik, Saglik Bilimleri University Izmir Bozyaka, Turkey

Title: **Laparoscopic Inguinal Hernia Repair TAPP under Regional Aneshesia: Clinical Experience**
Alexander Surya Agung, Bhayangkara Police Hospital, Indonesia

Title: **Observation of the pharynx to the cervical esophagus using transnasal endoscopy with image enhanced endoscopy**
Kenro Kawada, Tokyo Medical and Dental University, Japan

Wai-Kay Seto, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Non-invasive assessment of liver fibrosis and steatosis

Wai-Kay Seto
The University of Hong Kong, Hong Kong

Liver biopsy has long been an imperfect gold standard for the assessment of liver fibrosis. While liver biopsy is still widely considered in the disease assessment of viral hepatitis and non-alcoholic steatohepatitis, its invasive nature means it is seldom used to assess treatment response in stable and asymptomatic patients. Non-invasive methods of liver fibrosis are gradually emerging. Serum-based markers e.g. enhanced liver fibrosis score have been shown to correlate strongly with actual histology for multiple chronic liver diseases. Another method of assessing is liver stiffness measurements via transient elastography, a non-invasive ultrasound-based method that is easily performed with high reproducibility. Liver stiffness measurements have been well-validated in chronic hepatitis B, chronic hepatitis C and non-alcoholic fatty liver disease. In addition, liver stiffness measurements have been shown to have prognostic value on the development of cirrhotic complications, hepatocellular carcinoma and all-cause mortality. Evidence on the role of liver stiffness measurement in the clinical monitoring of treatment response is also emerging. Transient elastography also allows the measurement of controlled attenuation parameter, a quantitative marker of steatosis. Transient elastography is now recommended by multiple international guidelines as an assessment tool for chronic liver diseases. There are also other methods of liver fibrosis assessment, e.g. magnetic resonance imaging-based methods that are currently in development.

Biography

Wai-Kay Seto completed his Medical degree in 2003 and Doctor of Medicine in 2012. He is currently a Clinical Associate Professor in Department of Medicine at University of Hong Kong. He is also a fellow in Gastroenterology and Hepatology and Consultant of Medicine at University of Hong Kong-Shenzhen Hospital, Shenzhen, China. He has published more than 100 peer-reviewed articles in high-impact peer-reviewed journals, including first-authored articles in *Journal of Clinical Oncology, Gut, Hepatology, Journal of Hepatology* and *American Journal of Gastroenterology*. He has been awarded numerous research awards by Hong Kong College of Physicians.

wkseto@hku.hk

Notes:

Esam Elshimi et al., J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Current safety and feasibility of ERCP in management of early and late post liver transplant biliary complications

Esam Elshimi, Ahmad Attia, Gamal Badra and **Ashraf Eljaky**
Menoufia University, Egypt

Background & Aim: Biliary complications after living donor liver transplantation (LDLT) represent the most challengeable burden after OLT. Aim of this study was to study safety, feasibility and the clinical and biochemical changes before and after endoscopic therapy for biliary tract complications after living donor liver transplantation.

Patients & Methods: This was a retrospective and prospective study between April 2014 and December 2015, we reviewed the medical records of 108 patients with LDLL. ERCP procedure was indicated in 30 patients (28 males, aged 50.13±5.05 years and two females, aged 51±7 years) for biliary tract complications after living donor liver transplantation at the National Liver Institute.

Results: Biliary stricture was the highest reported complication (56.7%) followed by leakage (53.3%). The lowest were dilatation of common bile duct (sphincter of Oddi dysfunction), and cholangitis; each of them accounts for 3.3% from the total complication. Post ERCP complications were pancreatitis and bleeding in one case for each. Most of patients were HCV positive (50%) followed by chronic HCV and HCC (33.3%) the lowest cause was HCC alone (3.3%). Five patients suffering from pleural effusion prior to ERCP, mild ascites in 28 cases and moderate in two cases, all patients were cardiologically free. The frequency of complication was like one, two and three complications in 21, 7 and 2 cases respectively. The timing of complications was: In ≤3 month, 16 patients developed complication, 22 patients developed complication in 4-12 month, while only three patients developed complication >1 year. Post ERCP complications included mild pancreatitis and GIT bleeding in one patient for each, there were significant changes regarding all liver profile after LDLT before any complication and on the day of presentation (during complication) and between the last one and follow up (one month) after ERCP therapy ($p<0.05$). However, there was no significant difference in liver profile between before any complication and follow up (one month) after ERCP therapy ($p>0.05$).

Conclusion & Recommendation: ERCP was safe and effective in treatment of post liver transplant biliary complications and should be recommended for all patients in this setting.

Biography

Esam Elshimi is working at Menoufia University, Egypt. He is the recipient of numerous awards for his expert research works in related fields. His research interests reflect in his wide range of publications in various national and international journals.

eelshimi@liver-eg.org

Notes:

Errawan R Wiradisuria, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Recent advances in common bile duct stones management

Errawan R Wiradisuria
Indonesian Society of Endo-Laparoscopic Surgeons, Indonesia

Since laparoscopic cholecystectomy was done for the first time by Philippe Mouret (France, 1987), the development of minimally invasive surgery in hepatobiliary system have been progressing, followed by Berci, Phillips (USA, 1991) who has done laparoscopic common bile duct exploration (LCBDE) successfully later on. Abnormal intra operative cholangiogram, unsuccessful attempts at endoscopic stone extraction for large/occluding stones, and intra hepatic stones are the indications for a LCBDE. While contraindications for the procedure, such as inability of the surgeons to perform the necessary maneuvers, absent of indication, instability of the patient, local condition in the porta hepatic made exploration hazardous, diameter of cystic duct less than 4 mm (transcystic procedure) or diameter common bile duct (CBD) less than 6 mm (transcholedochal). Three major options in management of cholelithiasis with CBD stone were open cholecystectomy with CBD exploration, endoscopic sphincterotomy and stone extraction followed by laparoscopic cholecystectomy (two stages) or laparoscopic cholecystectomy and laparoscopic CBD exploration done in one stage. Choice of the treatment was based on patient safety consideration, time efficiency, and cost effectiveness. Surgeons' competency becomes an important role to determine a successful LCBDE. Availability and preparedness of instruments/equipment included Endoscopic Retrograde Cholangiopancreatography (ERCP) facilities are also the crucial supporting factors. LCBDE in Jakarta was done from August 2004 to July 2016 with 44 cases. Mean age of the patients were 52 years. Mean operation time was approximately 3.5 hours, with mean hospital stay about 5.5 days. Conversion of the operation was caused by impacted stones, massive adhesion (anatomical reason) or instrument failures. Several complication or morbidity after the surgery included retained stone, subphrenic abscess, T-tube insertion leakage, respiratory tract infection, urinary tract infection and superficial wound infection. Recently, the LCBDE become an important alternative choice in treatment of CBD stone, especially in the failure of ERCP/endoscopic stone extraction. LCBDE as a minimal invasive procedure has the advantages with high success rate, low morbidity and mortality rate and faster post-operative period recovery. However, we still need more training and learning curve.

Biography

Errawan R Wiradisuria is the President of Indonesian Society of Endo-Laparoscopic Surgeons and Chairman of Advance Laparoscopic Surgery courses (Asia-Pacific). He has published numerous papers in reputed journals and has been serving as an Editorial Board Member of repute.

errawan.w@gmail.com

Notes:

Bulent Calik, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Acute pancreatitis cases in Turkey: A review of the literature from 1980 to 2016

Bulent Calik
Tepecik Education and Research Hospital, Turkey

This study is a review of the literature related to acute pancreatitis in Turkey. In order to find the published reports on this subject, national database (Tubitak Ulakbim Turkish Medical Literature database, http://www.turkishmedline.com, and two international databases [Index Medicus and Science Citation Index (SCI)-expanded] were searched. Key words for national database were acute pancreatitis, akut pankreatit and the key words for index medicus and SCI-e were acute pancreatitis and Turkey. More than three published case reports were included. Data for 959 patients with acute pancreatitis were obtained from 13 reports. Of the patients, 381 (40%) were males and 578 (60%) females. Their ages ranged from 16 to 107 years. Etiological factors were biliary in 674 (70%), alcohol in 70 (7%), hyperlipidemia in 40 (4%), diuretic usage in 12 (1%) and trauma in 11 (1%). 152 of all patients (16%) etiology were non-specific. Mortality was seen in 128 cases (13%). 265 (28%) patients had necrotizing pancreatitis. Of these necrosis rate is less than 30% in 76 (29%), 30-50% in 70 (26%), 50% in 107 (40%) patients. 12 patients (5%) had extra-pancreatic necrosis. 49 patients (5%) had abscesses in abdomen, 35 patients (4%) had pancreatic fistula, 16 patients (2%) had pseudocyst, 12 patients (1%) had bleeding into the abdomen, 10 patients (1%) had bile fistula, 10 patients (1%) had enterocutaneous fistula and seven patients (1%) had pancreatic abscesses. 12 patients (1%) had endocrine pancreatic insufficiency, three patients (0.3%) had exocrine pancreatic insufficiency. 59 of all patients (6%) developed multiple organ failure. Relaparotomy was performed in 19 patients (7%) with necrotic pancreatitis. Despite continuing technological advances in diagnosis and treatment, acute pancreatitis remains a disease with high morbidity and mortality.

Biography

Bulent Calik has completed his MD at Cukurova University, Turkey and Post-doctoral studies at Saglik Bilimleri University, Tepecik Education and Research Hospital in General Surgery department. He is the Chief Assistant at Saglik Bilimleri University İzmir Tepecik Education and Research Hospital. He is interested in Oncological Surgery, Robotic Surgery, Laparoscopic Surgery and Colorectal Surgery. He has published more than 20 papers in reputed journals and has been serving as an Editorial Board Member of repute.

calikbulentdr@yahoo.com

Notes:

Liana Kurmanseitova et al., J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Complications of antegradny access at the decompression of bilious channels in patients with mechanical jaundice and ways of their treatment

Liana Kurmanseitova, Baycherov E and **Dzhanibekova M**
Stavropol State Medical University, Russia

Introduction: Percutaneous transhepatic drainage of the bile duct and its tributaries is performed for the patients who have unresectable tumor of the hepato-duodenal area with obstruction of biliary system; only when it is not possible to drain by endoscopy due to dramatic pathological changes in the region or low performance status of the patient. This procedure improves the quality of life and overall survival without changing disease prognosis.

Aim: The aim of the study is the efficacy and safety assessment of percutaneous techniques installation of biliary drainage systems, and differentiate possible complications and there treatment.

Method: From 2014 to 2015, the clinic endoscopic and minimally invasive surgery at Stavropol State Medical University (StSMU) had 112 inpatients with obstructive jaundice. All patients underwent percutaneous transhepatic drainage of the bile duct and its tributaries. Total 128 operations were done. The average patient age was 65.5 years; mean bilirubin level at admission was 253.

Results: We performed 128 operations on patients. In all cases, the biliary system was drained effectively. In 41.4% mounted external drainage, 32% of the external-internal drainage, 4% drainage bilobar, 6.2% bile duct stent, 3.1% "rendez-vous" passage technique of benign strictures of the common bile duct. In 1.5% of cases, after the drainage of the biliary ducts, hemobilia occurred that was resolved conservatively by the change of drainage and washing. In 13.2% of cases of cholangitis after drainage, in all cases, they were treated conservatively. Allergic reaction was observed to the anesthetic 2.3% (three patients). Leakage of bile into the abdominal cavity was seen because of drainage migration in 1.5% (two patients). The lethal outcome of 0.5% (within seven days of observation) and the duration of hospitalization were three days for the early ambulated patients- fast track.

Conclusion: Percutaneous transhepatic drainage of the bile duct and its tributaries is an important alternative to endoscopic drainage. This intervention is shown to extend the lives of patients with malignant stricture with a low level of survival. Treatment of postoperative complications, the ante-grade way of interventions in most cases doesn't demand performance of open operations.

Biography

Liana Kurmanseitova completed her PhD in Medicine at Moscow State University of Medicine and Dentistry. She is a Professional Surgeon in the field of Intervention Surgery and currently employed at the clinic of endoscopic and minimally invasive surgery under Stavropol State Medical University. She has a vast experience in the "Medical treatment of patients with obstruction jaundice". She has participated in more than 15 international conferences and performed two on-line workshops for the wide audience.

kurmanseitova@hotmail.com

Notes:

Cheng Zhang, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Ulcerative colitis associated colorectal cancer patients who receives colorectal surgery more likely receive blood transfusion and parental nutrition than Crohn's disease associated colorectal cancer patients - A propensity match study

Cheng Zhang
Ohio State University, USA

Introduction & Aim: The health care resource utilization of inflammatory bowel disease (IBD)-associated CRC patients who undergo colorectal surgery is unknown. Aim of this study was to compare the health care resource utilization, particularly the requirements of blood transfusion and parental nutrition, between ulcerative colitis (UC)-associated colorectal cancer (CRC) and CD-associated CRC who receives colorectal surgery.

Methods: This was a cross-sectional study using data from the Nationwide Inpatient Sample. UC- or Crohn's disease (CD)-related and CRC-related hospitalizations that underwent colorectal surgery between 2008 and 2012 were identified using appropriate ICD-9-CM codes. Exclusion criteria included: Age<18 years; carrying discharge diagnosis of both ulcerative colitis and Crohn's disease (CD); CD with small intestine involvement only and; patients with missing data among the variables of interest. The health care resource utilization, including receiving blood product and parental nutrition was compared between UC-associated and CD-associated CRC patients who underwent colorectal surgery. Statistical analysis: A propensity match study was used to compare the outcomes between these two groups.

Results: There were a total of 197 pairs of patients in each UC-associated CRC and CD-associated CRC group and they matched well with respect to demographics, comorbidities, and institutional characteristics. We performed McNemar's tests for categorical variables in the matched sample. UC-associated CRC patients who receive colorectal surgery more likely receive blood transfusion (p=0.0039) and parental nutrition (p=0.0203) when compared with CD-associated CRC patients (Table 1). In addition, the CRC location is also different between UC- and CD-associated CRC (p=0.0006). More CD-associated CRC patients have right-sided colon lesions. CD-associated CRC patients more likely received partial colectomy than UC-associated CRC patients (p<0.0001) (Table 2).

Discussion: Inflammatory bowel disease (IBD) is associated with an increased risk of CRC. In contrast to sporadic CRC, IBD-associated CRC is frequently diagnosed at a more advanced stage and tumors are often multiple and poorly differentiated. Because UC and CD have different pathophysiology, subsequently, the phenotype and response to treatments including colorectal surgery between UC- and CD-associated CRC would be different. Our study is the first to examine the health care resource utilization in UC- and CD-associated CRC who receives colorectal surgery. Colorectal surgery in UC-associated CRC patients has been associated with higher health care resource utilization, including blood transfusion and parental nutrition, when compared with CD-associated CRC. In addition, the location and type of colorectal surgery are also different between these two groups. This study suggested that the surgical treatment for UC- and CD-associated CRC is different and therefore, care of IBD-associated CRC around colorectal surgery should be treated differently between UC and CD patients.

Biography

Cheng Zhang completed his MD at Hunan Medical University in China in 1995. After he completed his PhD in the field of Molecular Biology at University of Southern California in 2005, he completed his Medicine Residency training at Greater Baltimore Medical Center affiliated to the Johns Hopkins University in Baltimore in 2009 and Gastroenterology fellowship training at Beth Israel Deaconess Medical Center, Harvard Medical School, in Boston in 2012. Now, he is an Assistant Professor at Ohio State University in Columbus, Ohio. He is also a fellow of American College of Gastroenterology (ACG). His clinic interest is on Inflammatory Bowel Disease (IBD) and his research is focused on IBD outcome research and IBD translational research, including JAK-STAT signaling pathway in IBD. He has numbers of peer-peer reviewed publications, oral presentations in multiple international conferences, and many awards from gastroenterology associations.

zhang.4567@osu.edu

Sebnem Calik, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Colonoscopy and infectious disease

Sebnem Calik
Saglik Bilimleri University, Turkey

Colonoscopy is the endoscopic examination of the large bowel and the distal part of the small bowel with a camera on a flexible tube passed through the anus. It can provide a visual diagnosis (e.g. ulceration, polyps) and grants the opportunity for biopsy or removal of suspected colorectal cancer lesions. Complications of colonoscopy are rare. These complications are perforation, bleeding, anaesthesia related bowel preparation and infection. The rate of infection was found as 1/1.8 million. The risk of infection development differs depending on gastrointestinal system region in which the endoscopic procedure is performed, and on type of procedure, and on patient's underlying disease. The incidence of bacteremia after colonoscopy whether with or without biopsy and polypectomy varies between 0 and 25%. Bacteremia developing in immuno competent patients during or after colonoscopy is generally transient or asymptomatic. The incidence of transient bacteremia in flexible endoscopes varies between 0 and 1%. Colonoscopy related infections are of two forms: 1) Endogenous infection: The spread of patients own microbial flora in gastrointestinal system to other organs or prosthesis via the bloodstream during colonoscopy. Endoscopic procedures most often result in endogenous infections (i.e., infections resulting from the patient's own microbial flora), and *E. coli, Klebsiella* spp., *Enterobacter* spp., and *Enterococci* are the species most frequently isolated. 2) Exogenous infections: The spread of microorganisms from one patient to other patient by a contaminated endoscope (opportunistic pathogens such as bacteria, HBV, HCV, fungi, parasites etc.). The important risk factors of exogenous infections in colonoscopy are the number of microorganisms present inside the endoscope or biofilm production, invasive procedure which is resulting tissue damage, immuno compromised status of the patients (malignancy, solid organ transplantations, immunosuppressive treatment, human immunodeficiency virus, etc.) and presence of infectious focus during colonoscopy. Such infections are preventable with strict adherence to accepted reprocessing guidelines.

Biography

Sebnem Calik has completed her MD at Trakya University and Post-doctoral studies at Ege University, Medical Faculty of Infectious Diseases and Clinical Microbiology Clinic. She is a Specialist at Saglik Bilimleri University, İzmir Bozyaka Education and Research Hospital, Infectious Diseases Department. She is interested in Febrile Neutropenia, Bloodstream Infection, Nosocomial Infection and Fungal Infection. She has published more than 20 papers in reputed journals and has been serving as an Editorial Board Member of repute.

calikbulentdr@yahoo.com

Notes:

Alexander Surya Agung et al., J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Laparoscopic Inguinal Hernia Repair TAPP under Regional Aneshesia: Clinical Experience

Alexander Surya Agung and **Agus Setiyana**
Bhayangkara Police Hospital, Indonesia

Objective: Laparoscopic inguinal hernia repair transabdominal preperitoneal (TAPP) is conventionally done by general anesthesia. This procedure can be performed by regional anesthesia. We present four years of experiences (Jan 2012–Dec 2015) using regional anesthesia for laparoscopic inguinal hernia repair TAPP to assess the feasibility and safety of this procedure.

Methods: Between Jan, 2012 to Dec, 2015, 93 patients with inguinal hernias, ASA I & II, underwent TAPP repair under loco regional anesthesia [spinal/peridural/combined, sedation (Midazolam) and analgesia (morphine/fentanyl)], spinal anesthesia level VL III–IV, Spinocan 29G with block target VTh IV-V using a low pressure CO2 (10–12 mm Hg) pneumoperitoneum. Strangulated and obstructed patients were excluded but irreducible were included. All defects covered by low weight plain mesh 10x15 cm and fixated by secure strap. Patients were followed up over one year period.

Results: There was neither conversion from spinal anesthesia to general anesthesia nor to opened surgery. Age: 17–53 years (average: 32 years), sex: male 88 patients, female five patients. Defects: unilateral 88, bilateral five, six patients with recurrent case. Operating time: 30–135 minutes (average: 60 minutes). Average hospital stays one, five days (one–two days). Two patients complained of shoulder pain, two patients suffered bradycardia and one hypotension intra operatively. There were no postural headache, PONV (post-operative nausea and vomiting) and urinary retention found.

Conclusion: TAPP repair is feasible and safe under regional anesthesia. Further studies are required to validate this technique.

Biography

Alexander Surya Agung is a Head of Surgery department at Bhayangkara Police Hospital, Surabaya, Indonesia. He completed his Medical Doctor at University of Airlangga, Surabaya-Indonesia and; General Surgeon at University of Airlangga, Surabaya-Indonesia. He is interested in Minimally Invasive Surgery and, attended courses at Singapore, India, Taiwan and Philippines. He is a member of Indonesian Endo-Laparoscopic Society, Indonesian Hernia Society, Endoscopic and Laparoscopic Surgeons of Asia, Asia Pacific Hernia Society and European Association for Endoscopic Surgery.

alx.surg@gmail.com

Notes:

Kenro Kawada, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Observation of the pharynx to the cervical esophagus using transnasal endoscopy with image enhanced endoscopy

Kenro Kawada
Tokyo Medical and Dental University, Japan

The more progress achieved in endoscopy, the more superficial cancers in the head and neck regions associated with esophageal squamous cell carcinoma have been found. Between August 1996 and March 2017, we have been experienced 350 cases of superficial head and neck cancers. Some areas difficult to observe with trans-oral endoscopy because of gag reflex. We applied new trans-nasal esophagogastroduodenoscopy (EGD) with image enhanced endoscopy (narrow band imaging, blue laser imaging, and linked color imaging) and modifications of endoscopic techniques for observing head and neck cancers and obtaining excellent results. The patient was asked to bow their head deeply in the left lateral position, and then we kept our hand on the back of the patient's head and pushed it forward by one span of our hand. Then, he was asked to lift up their chin as far as possible. After the local anesthesia of the nose without sedation, the endoscope was inserted through the nose. When inspecting the hypopharynx and the orifice of the esophagus, we asked the patient to blow hard and puff his cheeks with his mouth closed. This procedure provided a much better view of the orifice of the esophagus than had been possible with trans-oral endoscopy. Furthermore, observing the base of the tongue using trans-oral endoscopy is also difficult. When inspecting the oropharynx, the patient opens their mouth wide and sticks their tongue out as far as possible while making a vocal sound similar to a long I. The endoscopist then forces the transnasal-endoscope to make a U-turn, and observes the oropharynx, in particular the base of the tongue. Mucosal redness, a pale thickened mucosa, white deposits, or loss of a normal vascular pattern, as well as demarcated brownish areas with image enhanced endoscopy, are important characteristics to diagnose superficial carcinoma.

Biography

Kenro Kawada completed his Graduation in 1995 at Tokyo Medical and Dental University. He worked at Medical Hospital, Tokyo Medical and Dental University in 1995 and 2001. He was Junior Associate Professor in Department of Gastrointestinal Surgery at Tokyo Medical and Dental University in 2008.

kawada.srg1@tmd.ac.jp

Notes:

Bariatrics and Gastrointestinal Emergencies | Colorectal: General and Colorectal Cancer: An Overview

Session Chair
David H Van Thiel
Advanced Liver and Gastrointestinal Disease Center, USA

Session Co-chair
Errawan R Wiradisuria
Indonesian Society of Endo-Laparoscopic Surgeons (ISES), Indonesia

Session Introduction

Title: **Current criteria for colostomy in trauma**
Luis A hernandez Higareda, Hospital of Traumatology "Lomas Verdes". (HTOLV). IMSS, Mexcico

Title: **First results of modified diagnostic scale use for patients with possible appendicitic**
Alexander Natroshvili, I.M. Sechenov First Moscow State Medical University, Russia

Title: **Recent Advances in Surgical Endoscopy**
Reno Rudiman, Padjadjaran University, Indonesia

Title: **Laparoscopic Colorectal Surgery**
M Iqbal Rivai, Andalas University, Indonesia

Title: **Update of stapled anorectal surgery**
Chung-Hung Yeh, St. Martin De Porres Hospital, Taiwan

Title: **Colorectal cancer: Current issues in Bulgaria**
Radosvet Gornev, University Hospital Lozenentz Sofia, Bulgaria

Title: **Therapeutic strategies for four subtypes of laterally spreading tumors (LSTs) of the colorectum**
Yoriaki Komeda, Kindai University, Japan

Luis A hernandez Higareda et al., J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Current criteria for colostomy in trauma

Luis A hernandez Higareda and **Carrasco R A**
IMSS Hospital de Traumatología y Ortopedia "Lomas Verdes", Mexico

Background & Aim: There is no consensus in Mexico on the criteria for colostomy in trauma. We have reported in the world literature reports since 1990 recommending primary closure in colon lesions up to 96%. This generalized primary closure in our country is not feasible. The surgeon must decide between performing an anastomosis or a colostomy. We analyzed the main criteria for colostomy in severe polytraumatized patients with colon injury.

Material & Methods: In a prospective cohort of polytraumatized patients with colostomy, the main criteria for colostomy in trauma in three years were analyzed.

Results: In the first three years, 270 laparotomies were performed per year, with a total of 70 colon lesions, 65 per perforation (excluding two intraoperative deaths). Of the 63 patients, primary closure was performed in 29 (46%): Colostomy was performed in 34 patients (54%). Criteria found for colostomy: Location of the lesion in the left colon (used as a criterion for the left localization of the colon) in 50%, PATI (Penetrating Abdominal Trauma Index) in 50%, ISS (Injury Severity Score) in 47%, flint (criteria of flint) in 82% and stone and fabian (criteria by stone and fabian) by 91%. The latter always took into account the need for resection of the colon and significant loss of the abdominal wall. Of the remaining five criteria of stone and fabian were found: At preoperative pressure less than 60 to 80 mm Hg in nine (26%), to intraperitoneal hemorrhage>1000 cc in 11 (32%), to more than two intraperitoneal organs lesions in 19 (56%), major intraperitoneal dissemination of feces in 13 (38%) and with more than 8 hours of injury at the time of surgery in two (6%).

Conclusion: According to the trend shown by the results of this cohort, the criteria most taken into account in this hospital are those of stone and fabian. These criteria are considered in 100% to the patient that requires colon resection and those with significant loss of the abdominal wall.

Biography

Luis A hernandez Higareda completed his Pre-grade in Biological Sciences at cyto-histopathology clinic and medicine at University of Guadalajara. He did his Post-graduation in Intensive Care, Clinical Epidemiology, and Master of Surgery at National Medical Center West, Mexican Social Security Institute (IMSS)-University of Guadalajara. He has undergone training in Gastrointestinal and Airway Endoscopy and Thoracoscopy at National Medical Center La Raza, IMSS, National Autonomous University of Mexico (UNAM). He completed courses in General Surgery and Endoscopic Ultrasound from XXI Century National Medical Center IMSS. He was trained in Surgery of Trauma at Trauma Hospital Lomas Verdes IMSS.

doctor_la_hh@hotmail.com

Notes:

Alexander Natroshvili, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

First results of modified diagnostic scale use for patients with possible appendicitis

Alexander Natroshvili
I.M. Sechenov First Moscow State Medical University, Russia

Background: Acute appendicitis is still a diagnostic challenge. Different scoring systems are designed to aid in the diagnosis of this common disease, including Alvarado score, recent appendicitis inflammatory response score, etc. Ultrasonography is widely used imaging modality that increases diagnostic accuracy, but false negative result rate is relatively high, leading to increased risk of misdiagnose acute appendicitis. Limitations of this diagnostic method led us to development of new diagnostic scale.

Materials & Methods: Retrospective study of 231 proved acute appendicitis cases was performed to detect the most sensitive and specific clinical signs and lab parameters. Using this data and statistical analysis, we developed diagnostic scoring system, that included clinical signs, blood test and ultrasonography results. Prospective study included 43 consecutive patients with suspected acute appendicitis. Physical examination, ultrasound, laparoscopy and appendectomy were performed by the same surgeon. Diagnosis of appendicitis was confirmed or excluded histologically in all specimens.

Results: Our scoring system allowed to diagnose appendicitis in 27 of 28 histologically proven cases, to exclude it correctly in 14 of 15 cases. According to protocol, four patients with equivocal diagnostic scale result underwent laparoscopy that diagnosed appendicitis in one case (false-negative result). Histology didn't confirm acute appendicitis in one case (false-positive result). Diagnostic scale sensitivity was 96.4%, specificity 93.3%, accuracy 95.3%, positive predictive value 96.4%, negative predictive value 93.3%. Negative appendectomy rate was 3.7%.

Conclusion: First results showed that developed scoring system is highly sensitive and specific in detecting acute appendicitis. It could aid in selecting patients who require immediate surgery or those who require further evaluation. Proper prospective randomized trial evaluating the effect of such scoring system must be performed before recommending this scoring system for wide use.

Biography

Alexander Natroshvili has completed his PhD at I.M. Sechenov First Moscow State Medical University. He is an Assistant Professor at I.M. Sechenov First Moscow State Medical University, Head of Department at University Hospital. He has published more than 25 papers in reputed journals.

Alexander@natroshvili.ru

Notes:

Reno Rudiman, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Recent advances in surgical endoscopy

Reno Rudiman
Padjadjaran University, Indonesia

Gastrointestinal endoscopy is a medical instrument for examining the interior canal of digestive tract. The use of the tool has been reported as early as 1822 by William Beaumont. Modern endoscopy as what we now daily use, has been invented in 1983. Various digestive diseases that previously must be diagnosed and treated by invasive method can now take the advantage of flexible endoscopy with ease of procedure and excellent diagnostic accuracy, and can even achieve therapeutic results without open surgery. This presentation will show a brief history of GI endoscopy, listing indications of endoscopy, and more importantly will show recent advances in the field of surgical endoscopy. Clinical results, success rate as well as its complications will be discussed.

Biography

Reno Rudiman is a Digestive Surgeon at Hasan Sadikin Hospital in Bandung, Indonesia. He completed his Master's degree at University of Aberdeen, UK and PhD at Universitas Padjadjaran, Indonesia. He also completed his training in General Surgery and Digestive Surgery at Universitas Padjadjaran. He has published numerous national as well as international publications on surgery. He has a special interest in Minimal Invasive Surgery. He was among the first surgeons in Indonesia licensed to perform robotic surgery. He is a national faculty member of the Indonesian Society of Endolaparoscopic Surgery, and regularly teaches Endolaparoscopy.

rudiman@unpad.ac.id

Notes:

M Iqbal Rivai, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Laparoscopic colorectal surgery

M Iqbal Rivai
General Hospital of Dr. M. Djamil Padang, Indonesia

Traditionally, operation on the colon and rectum required a large abdominal and /or pelvic incision, which often required a lengthy recovery. New instrumentation and techniques allow the surgeon to perform the procedure through several small incision, what we now refer to as "minimally invasive", "laparoscopic" or "laparoscopic-assisted" colorectal surgery.

Minimal invasive surgery can be successfully performed for variety of common benign and rectal conditions including diverticulitis, colon polyps, inflammatory bowel disease (Crohn's Disease and ulcerative Colitis), rectal prolapse and malignancy. It ca be used to remove the entire colon and rectum or just portion, or segment, of the colon. Minimally invasive techniques can be used to create an ostomy. They may be either colostomy or an ileostomy. Also, minimally invasive techniques can be used to reconnect the intestine from a temporary ostomy. There are very few traditional abdominal colon and rectal procedure that cannot be performed in a minimally invasive manner.

Laparoscopic colorectal surgery refers to a technique where surgeon makes several small incision, instead of a single large incision. For most colon and rectal operation, 3 – 5 incisions are needed. Small tubes, called "trocars" are placed through these incision and into abdomen. Carbon dioxide gas is used to inflate the abdomen in order to give the surgeon room to work. This allows to surgeon to use a camera attached to a telescope to watch a magnified view of the inside the abdomen on operating room monitors.

Laparoscopic colorectal surgery is a significantly more challenging operation as it frequently involves often more than one abdominal quadrant, identification and transection of vascular structures, mobilisation and resection of the bowel, retrieval of the surgical spesimen and performing an anastomosis. The greater complexity of laparoscopic colectomy has been associated with longer operative times and long learning curve. Ileo-colic resection, segmental colectomy or anterior resection of the rectum for cancer, segmental colectomy for benign disease and rectopexy can perform laparoscopically.

Results are different for each procedure and each patient, some common advantages of minimally invasive colorectal surgery are shorter hospital stay, shorter recovery time, less pain from the incisions, faster return to normal diet, faster return to work or normal activity, better cosmetic healing. Many patients qualify for laparoscopic or minimally invasive surgery. However, some conditions may decrease a patient"s eligibility, such as previous abdominal surgery, cancer (in some situation), obesity, variations in anatomy or advanced heart, lung, or kidney disease.

In Indonesia laparoscopic colorectal surgery has been frequently used. Especially in my area west Sumatra, 3-5 patients per day underwent laparoskopic appendictomy and 5-7 patients each month with colonic malignancy performed laparoscopic approach such as laparoscopic hemicolectomi, low anterior resection and surgical redundant sigmoid. The choice of therapy affected by many factors. On a few occasions, an operation may be started laparoscopically and subsequently converted to an open operation due to technical factors such as bleeding or inability to clearly see and recognise the area to be operated on.

Since 2011 has been nearly 300 cases of colorectal malignancy that do minimally invasive surgical therapy. At 3 years, the locoregional recurrence rate was 5.0% in the two groups. Disease – free survival rates were 74.8 % in the laparoscopic surgery group and 70.8% in open surgery group. Overall survival rate were 86.7% in the laparoscopic surgery group and 83.6% in the open-surgery group.

Biography

M Iqbal Rivai is currently working in General Hospital of Dr. M. Djamil Padang, Indonesia. He has worked for more than 10 years in the related field and gained a plethora of knowledge in related field. His international experience includes various programs, contributions to reputed journals and participation in different international conferences in diverse fields of study.

rivai_m.iqbal@yahoo.com

Chung-Hung Yeh, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Update of stapled anorectal surgery

Chung-Hung Yeh
St. Martin De Porres Hospital, Taiwan

Surgical stapling technique was pioneered by a Hungarian surgeon, Dr. Humer Hultl, known as the "father of surgical stapling". In the early 1900s, many of the basic principles of mechanical stapling began to emerge. After one-century's development, all kinds of devices were invented, including linear staplers, linear cutters, and circular staplers. The staplers also make minimally invasive surgery possible. There are plenty of endoscopic staplers were designed, and these were utilized in chest surgery, gastric surgery, bowel surgery, and many other surgical procedure. The surgical staplers were also used in anorectal surgery. The circular staplers have been used for low and very low bowel anastomosis to avoid permanent colostomy for decades. Stapled transanal mucosectomy, firstly aims to treat rectal internal mucosal prolapse and obstructed defecation, and was later proposed by Dr. Antonio Longo for the treatment of hemorrhoids in 1993. Subsequently called stapled hemorrhoidopexy or procedure for prolapsed hemorrhoids (PPH), the technique gained a wide popularity due to the low postoperative pain. In 2005, the practice parameters of the American Society of Colon and Rectal commended: Stapled hemorrhoidopexy is a new alternative available for individuals with significant hemorrhoidal prolapse. Then, also proposed by Dr. Longo, a rectal wall resection with a circular stapler was the basis for the development of the stapled transanal rectal resection (STARR) procedure. This procedure consists of a double transanal rectal resection and is aimed at correcting the anatomical anomaly of the rectum in patients with rectocele and/or rectal intussusception causing obstructed defecation. Although, some exceptionally rare but potentially devastating complications include anovaginal fistula, substantial hemorrhage, fistula, retroperitoneal sepsis, and rectal perforations have been reported after stapled anorectal surgery, the documented adverse events scattered and presented as case-report. When the procedures of PPH and STARR were accepted, more and more stapled anorectal rectal procedures have been presented, and the efficacy and safety of these new procedures will need further monitoring.

Biography

Chung-Hung Yeh has completed his Medical Degree at Taipei Medical University. After, he completed General Surgical training in 1995; he completed his Colorectal Surgical training at Chang-Gang Memorial Hospital (CGMH), and became the Director of Department of Colorectal Surgery at Chai-Yi CGMH from 2001 to 2009. He has published more than 25 papers in reputed journals and was a Senior Lecturer of Chang-Gang Medical School. He serves as Deputy Director of Surgical department at St. Martin De Porres Hospital since 2013.

yin0321@gmail.com

Notes:

Radosvet Gornev, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Colorectal cancer: Current issues in Bulgaria

Radosvet Gornev
Lozenetz Hospital, Bulgaria

Statement of the Problem: According to National Cancer Register, colorectal cancer is the third most commonly diagnosed cancer and the second leading cause of cancer death in Bulgaria. In 2013, new colorectal cancer patients are 2676 and all data shows increase of the number for the next years. Due to leak screening program and poor prophylaxis most of the cases (40%) are present in an advance stage. Five years survival rates for stage I and II are 86% compare to only 8% in stage IV patient.

Methodology & Theoretical Orientation: Review of the literature and single-center study of 405 patients with colorectal cancer.

Findings: The aim of the study is to analyze the distribution of patients according to the disease stage. Most of the patients are diagnose preoperative as II a stage, but in a pathological examination the contribution between the stage II, III, IV is approximately same. 75.5% of all patients have one or more additional diseases that increases the risk of intra and postoperative complications

Conclusion & Significance: The poor prophylaxis and ineffective screening program leads to advance stage disease at time of diagnosis. Comorbidity, often with bad control in combination with advanced stage at the time of surgery is the main reason for lower survival rates in Bulgaria. This conclusion is proven by 10.4% less relative 5 years survival rate compare to all Europe.

Biography

Radosvet Gornev is a Head of General Surgery department at University Hospital Lozenentz Sofia, Bulgaria. He is an Assistant Professor of Surgery at Sofia University "St. Kliment Ohridski". He works at UH Lozenetz Sofia, Bulgaria since 2008. He has experience in "General and colorectal surgery, research, evaluation, teaching and administration both in hospital and education institutions". From 2008, he is a part of liver transplant program at UH Lozenez, Bulgaria. He has passed a lot of practical modules in different European countries and did research fellowship at Clivland Clinic, USA during 2003.

dr_gornev@abv.bg

Notes:

Yoriaki Komeda, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Therapeutic strategies for four subtypes of laterally spreading tumors (LSTs) of the colorectum

Yoriaki Komeda
Kindai University, Japan

Background & Aim: Laterally spreading tumors (LSTs) are generally defined as superficial lesions 10 mm in diameter that extend laterally rather than vertically along the colonic wall. They are divided into granular type and non-granular type; the former is further divided into homogenous (LST-G(H)) and mixed nodular (LST-G(M)) and the latter is subdivided into flat-elevated (LST-NG(F)) and pseudo-depressed(LST-NG(P)). It seems that the biological behavior is different among these four subtypes. The goal of this study is to clarify the endoscopic and pathological characteristics of each subtype and establish therapeutic strategies for LSTs based on the sub-classification.

Methods: We investigated consecutive 380 lesions of LST in 349 patients which were treated in our hospital between April 2010 and June 2014. The location, maximum diameter, invasive rate and the surface pit pattern were evaluated.

Results: The LST patients included 186 males and 163 females and the average age was 68.3 year old. The therapeutic method was EMR in 158 (piecemeal EMR: 41), ESD in 207 and surgery in 15. The most affected site by each subtype was the cecum LST-G(H), the rectum in LST-G(M), and transverse colon in LST-NG subtypes. The mean size was 29.5 mm in LST-G(H), 38.1 mm in LST-G(M), 20.5 mm in LST-NG(F), and 24.2 mm in LST-NG(P). The invasive rate in each subtype was 0.8%, 18.5%, 5.3%, and 15.9%, respectively. It seems that piecemeal resection is acceptable for LST-G(H) as the possibility of its being an invasive cancer is extremely low. Mixed granular type can also be treated with a snare provided that the nodular part cannot cut as piecemeal. It is sometimes difficult to predict in which part the flat-elevated type is invading. In such cases, the pit pattern observation is useful; when the pit pattern is type III L or IV, the corresponding part is not invasive but the area with type V pit pattern should not cut into pieces as this part is supposed to be invasive.

Conclusion: The biological behavior is difficult among the four subtypes of LSTs. We should predict the histology precisely and determine the therapeutic strategy based on the subtype and also the pit pattern of the lesion surface.

Biography

Yoriaki Komeda studied Medicine at Kitasato University in 1974. In 2001, he started his formal training in Internal Medicine at Nara Medical University. He completed his training in Gastroenterology and became a Specialist in Japanese Society of Gastroenterology in 2011. He was a Clinical Research Fellow at St. Mark's Hospital in London, UK in 2011 and Erasmus Medical Center in Rotterdam, Netherlands in 2012. He became a staff member in Gastroenterology department at Kindai University in 2014. His special interests are "Advanced interventional endoscopic techniques such as endoscopic treatment of early gastro-intestinal cancers". He has published more than 15 papers in reputed journals.

y-komme@mvb.biglobe.ne.jp

Notes:

11th Global Gastroenterologists Meeting

June 12-13, 2017 Rome, Italy

Young Research Forum

Shuaib Meghji, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

Comparison of the performance of LTBI screening to the BTS standards

Shuaib Meghji
University Hospital Southampton, UK

Background: Patients with severe Inflammatory Bowel Disease (IBD) are prescribed anti-TNF-α agents, if clinical need necessitates, whose immunosuppressive action can potentially reactivate latent tuberculosis infections (LTBI). Meticulous pre anti-TNF-α LTBI screening and management in accordance with the British Thoracic Society's (BTS) Guidelines is imperative for patient safety and public health.

Objective: A retrospective clinical audit was performed to evaluate the performance of University Hospital Southampton's Gastroenterology department in screening for LTBI in patients with IBD. The performance of LTBI screening was compared to the BTS standards.

Method: The audit population was obtained using the gastroenterology department's biologics database. Inclusion criteria included patients who started their first anti-TNF-α agent between 01/01/2006 to 04/11/2016. Exclusion criteria included deceased patients and patients screened by alternative departments/trusts. Extent of LTBI screening was assessed using hospital record systems: EDocs, EQuest, ECamis and Spectra PACS. If evidence of screening was not located, then this was considered as a failure to meet standard. Following statistical analysis, comparisons were made with BTS standards.

Results: Of the 471 patients audited, 51.2% were females and 48.8% males. 75.2% were CD patients and 24.8% were UC patients. 231 patients' (49%) LTBI screening was insufficient. 157 patients (33.3%) lacked an adequate TB history and 94 patients (20%) failed to have a chest radiograph (CXR) within three months of therapy commencement. Additionally, 85 patients (18.3%) failed to have an IGRA performed. 15 patients (3.2%) were diagnosed with LTBI, while one case of TB reactivation occurred once immunosuppressive therapy had commenced.

Conclusion: The completeness of LTBI screening in the audited group was suboptimal with deficits in TB history performance, CXR, TST and IGRAs. One case of active miliary TB occurred as a result of inadequate screening. In light of this, recommendations to address deficits and ultimately improve screening were proposed.

Biography

Shuaib Meghji is currently studying at University Hospital Southampton, UK.

shuaibmeghji94@gmail.com

Notes:

11th Global Gastroenterologists Meeting

June 12-13, 2017 Rome, Italy

Video Presentation

Gerard E Mullin, J Gastrointest Dig Syst 2017, 7:3(Suppl)
DOI: 10.4172/2161-069X-C1-049

The gut balance revolution

Gerard E Mullin
Johns Hopkins Hospital, USA

The pathophysiology of obesity is still unknown but there is mounting evidence that the gut microbiome, intestinal permeability and systemic inflammation may play an important role in disease pathogenesis and possibly treatment. Alterations in diet have been shown to shift the gut microbiome's effects on metabolism and regulation of body weight. This session will provide a focused overview of the scientific literature regarding the potential role of gut microbiome as a therapeutic target of weight management. The lecture will first review the pathophysiology of obesity from a functional medicine perspective and discuss how a functional medicine evidence-based approach can achieve optimal weight management by three steps: Remove; restore and renew. Learning objectives are to: Discuss the influence of the gut microbiome on energy metabolism; understand how disruption of the gut microbiome can lead to obesity and; know how prebiotic and probiotic foods and supplements may influence weight by favorably altering the gut microbiome.

Biography

Gerard E Mullin is a board-certified Internist, Gastroenterologist and Nutritionist. He is an Associate Professor of Medicine and Director of Integrative GI Nutrition Services at Johns Hopkins Hospital. He is regarded as an authority in integrative gastroenterology. He teaches medical professionals at international conferences on “The role of nutrition and lifestyle and the gut microbiome in digestive health and weight control”. He is the author of several professional desk references and trade books including his latest book *The Gut Balance Revolution: Boost Your Metabolism, Restore Your Inner Ecology, and Lose the Weight for Good!*

gmullin1@jhmi.edu

Notes: