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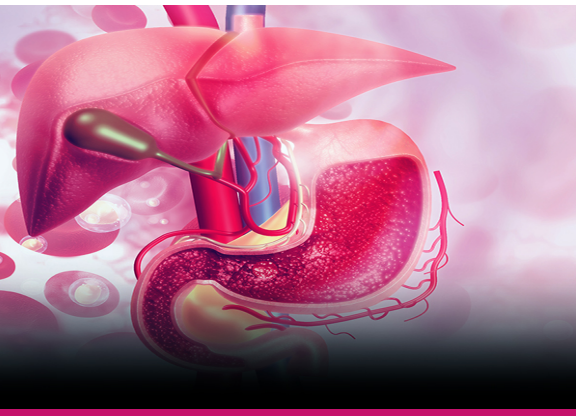
Enteron



Dear Doctor,

Greetings from Micro Labs limited.

Inside This Issue

Should you require any specific article or medical information, please feel free to contact us at medicalservices@microlabs.in Looking forward to your valuable feedback

COVID-19 Recommendations for PPE use during GI procedures issued by AGA

The American Association of Gastroenterologists issued COVID-19 guidelines for usage of personal protective equipment during gastrointestinal procedures, reported in Gastroenterology.

The suggestions were accepted by the Committee of Clinical Guidance of the AGA Institute, the Committee of Notifications on Clinical Practice of the AGA Institute and the Board of Governors of the AGA. The failure of monitoring for the infection would handle both patients as if they had COVID-19.

Recommendations for mask and glove use and triaging GI procedures include:

- All health care staff will carry N95 (or N99 or PAPR) masks for upper and lower GI procedures independent of COVID-19 status of a patient. AGA advises only for upper GI operations, in known or suspected COVID-19 cases, against surgical masks.
- For any GI treatment, double gloves will be used as opposed to single gloves, irrespective of the COVID-19 status of an individual.
- Negative pressure rooms should be used in proven or suspected COVID-19 cases, if available vs. a normal endoscopy room with every GI treatment.
- Continuation of standard cleaning endoscopic disinfection and reprocessing protocols regardless of COVID-19 status.
- Protocols will be checked by qualified emergency professionals as a basis for triage protocols and classified as either time-sensitive or not time-sensitive.
- In an open access endoscopy program, where guidance may offer adequate details to assess the time-sensitive complexity of the treatment, attention can be provided to make a choice for difficult patients with a mobile consultation with a referral doctor, a telehealth visits or a multidisciplinary team method.

Single high dose vs weekly vitamin D3 supplementation in pediatric patients with inflammatory bowel disease and hypovitaminosis D

INTRODUCTION

Vitamin D is instrumental to normal physiology, with a wide range of effects, from skeletal mineralization to immune regulation. Yet many children with inflammatory bowel disease (IBD), as many as 60-70%, are deficient. Deficiency may be associated with disease flare, nonadherence, or insufficient dietary intake.

Normalization, a medical care target, not only increases bone mineral density in IBD patients, but also reduces the likelihood of relapse through inhibiting proinflammatory cytokines by changes in the T cell balance. Vitamin D repletion methods are numerous. Various regimens are used for 5-8 weeks, varying from 4,000 IU of cholecalciferol every day to 50,000 IU maximum. The following system is at our heart the normal procedure. An alternative treatment is a continuous, high-dose oral vitamin D3 (stoss treatment) at 200,000 to 800,000 IU.

This technique can bring a major benefit as IBD teenagers who are reported to have a large incidence of non-adherence to medicine, possibly as large as 93%. This study's primary objective was to assess the effectiveness of a single high dose of oral vitamin D3 (stoss therapy) in children with inflammatory bowel disease (IBD) and hypovitaminosis D.

METHODS

A randomized, prospective study of 44 patients, age 6-21 years, with IBD and 25-hydroxyvitamin D (25-OHD) concentrations < 30ng/mL was conducted. Patients were randomized to provide 50,000 IU of vitamin D3 once a week for 6 weeks (care normal, SOC group) or 300,000 IU once (stoss group); Serum 25-OHD amounts were collected 4 and 12 weeks after baseline. At week 4, health testing laboratories is carried out.

RESULTS

Thirty-nine of forty-four enrolled patients (19 stoss, 20 SOC) completed the study. Baseline vitamin D levels were not significantly different between the groups. Stoss therapy resulted in a substantial rise in 25-OHD levels at week 4, equivalent to the weekly regimen (53.6 ± 17.3 ng/mL vs. 54.6 ± 17.5 ng/mL). At week 12, serum 25-OHD levels decreased in both groups, significantly lower in the stoss group, but remained close to 30 ng/mL (29.8 ± 7.1 ng/mL vs. 40.4 ± 11.9 ng/mL, p=0.04). A significant interaction with treatment group over time was observed (p=0.0003). At the week 4-time point, all patients who received stoss therapy had normal serum calcium and PTH levels. Eighty percent of patients preferred stoss therapy to the weekly regimen.

DISCUSSION

One of the key benefits of stoss therapy is that it decreases the cost of medication and maybe increases commitment as it is provided just once. Although virtually all patients obtaining weekly vitamin D therapy reported adherence to the course of care during the study period, adherence to the medication is undoubtedly a difficulty and burdensome for the patient in the real life environment. By the end of the analysis the patient sample of both categories showed a strong preference for our regular weekly therapy for the idea of stoss therapy. Hypercalcemia, hypoparathyroidism, and renal calculi are potential threats for stoss therapy. Many trials have demonstrated that in children with a vitamin D deficit with or without rickets, kidney failure, and cystic fibrosis supplementation can be utilized safely and effectively.

CONCLUSION

In addition, a daily high-dose (300,000 IU) vitamin D in children with IBD is a healthy and efficient form of therapy for addressing hypovitaminosis D. We understand that while stoss therapy has been shown to successfully raise rates of vitamin D without any symptoms of hypervitaminosis D, we have not shown the long-term clinical results for hypovitaminosis D in IBD infants. It needs a retrospective analysis assessing the rates of vitamin D with a higher dose of cholecalciferol and related clinical outcomes. Most patients favoured the idea of stoss therapy to weekly therapy which may be an answer to inadequate enforcement

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Long-term outcome of UDCA therapy in post-transplant patients of primary biliary cholangitis

INTRODUCTION

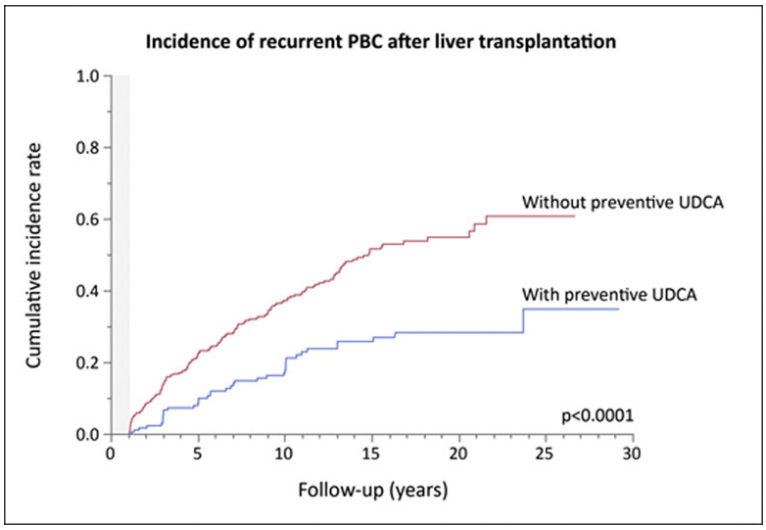
Recurrence of primary biliary cholangitis (PBC) following hepatic transplantation (LT) is common and may hinder the longevity of the graft and recipient. The new normal therapy for PBC is ursodeoxycholic acid (UDCA) We explored the impact of preventive exposure to UDCA on the frequency of PBC recurrence after LT and the long-term implications.

METHODS

We performed a longitudinal cohort analysis involving 780 patients transplanted for PBC in 16 centers and 9 countries from 1983 to 2017, and followed up over an 11-year median duration. 190 were preventively obtained by UDCA (10-15 mg / kg / d) among them. The primary outcome was the recurrence of PBC. The secondary outcomes were failure of the graft, mortality from the liver and mortality from all sources. The association between preventive UDCA and results has been quantified using multivariable-adjusted Cox models and a limited mean survival time (RMST).

RESULTS

While recurrence of PBC significantly shortened graft and patient survivals, preventive exposure to UDCA was associated with reduced risk for PBC recurrence (adjusted hazard ratio, 0.41; 95%CI, 0.28 – 0.61; p<0.0001), graft loss (0.33; 0.13 – 0.82; p<0.05), liver-related death (0.46; 0.22 – 0.98; p<0.05), and all-cause death (0.69; 0.49 – 0.96; p<0.05). RMST analysis showed consistent results with a survival gain of 2.26 years (95%CI 1.28 – 3.25) over 20 years. Exposure to cyclosporine rather than to tacrolimus added to the preventive effect of UDCA against PBC recurrence and all-cause death.



CONCLUSION

Preventive UDCA for PBC after LT is correlated with decreased likelihood of recurrence of illness, failure of the graft and death. The use of cyclosporine and protective UDCA regimens is correlated with the lowest probability of PBC recurrence and death.

Recurrence of primary biliary cholangitis (PBC) following hepatic transplantation (LT) is common and may hinder the longevity of the graft and recipient. The new normal therapy for PBC is ursodeoxycholic acid (UDCA) We explored the impact of preventive exposure to UDCA on the frequency of PBC recurrence after LT and the long-term implications.

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Corpechot C, et al. Long-term impact of preventive UDCA therapy after transplantation for primary biliary cholangitis. Jour of Hepatol (online) Apr 2020.