



**SRI LANKA**

# **GASTROENTEROLOGY**

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**The very first issue of the newsletter by SLSG ;  
“...Through knowledge for a better future!...”**



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# P resident's Message



Dear Colleagues and friends

As the President of the Sri Lanka Society of Gastroenterology, it gives me great pleasure to write a few words for the inaugural issue of the Society newsletter. Our Society, established in 1988 has gradually evolved into a premier professional body among the medical fraternity of this country. It is the vision of the Society to improve the knowledge and skills of the membership and improve the quality of work in the field of gastroenterology in Sri Lanka.

With this vision in mind, the council and I decided to launch this newsletter not only to keep the membership informed of the happenings within the Society but also to keep abreast of regional and global developments in the ever changing field of gastroenterology. It is also hoped that it would give the membership, which has now spread throughout the island a sense of belonging to a GI community. We are planning to have an issue every three months and the efforts of our editor, Dr Dinamitra and the other members in the team are greatly appreciated in making this a reality. Although we have been living under the cloud of the COVID-19 pandemic during the last few months, it has given us time to reflect inwards and address our deficiencies and visualize our future goals. This newsletter is one of them. Within the next few weeks we shall be moving into our own office which has been a long felt need of the society and I trust this will give more stability and stature to our Society.

Finally, let me thank the council for their unstinted support to launch this project and I wish the newsletter all success.

Best wishes and stay safe.

Dr. Sanjeewa Aryasingha

President, Sri Lanka Society of Gastroenterology

# H

## istory of the Sri Lanka Society of Gastroenterology

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The emergence of Gastroenterology as a specialty in medicine in Sri Lanka can be traced as far back as to 1965. In that year Prof. Kuwai Nakayama visited Sri Lanka from Japan and with that visit the sun began to rise and give light to Gastroenterology in this country. Prof. Nakayama was a giant in G I surgery – specializing in oesophageal surgery. He was a great craftsman with speed as his forte, doing three oesophagectomies during a morning session. At that time there was no Gastroenterology, let alone Gastroenterologists in this country, but the late Dr D F de S Goonewardene was known as “the surgeon for the stomach”. Prof. Nakayama valued his visit so much, that he decided to donate a gastroscope to Sri Lanka, but he could not give it to a single individual. So, the first Gastroenterology society was hurriedly formed to receive this donation, and Dr D F de S Goonewardene was elected

its first President. The society comprised of a cross-section of medical and surgical specialists in Colombo, which included even a chest physician. Prof. Nakayama donated the first flexible Gastroscope to this country, and was used exclusively by Dr D F de S Goonewardene on selected patients. However, the Gastroenterology Society had very few activities like an occasional lecture by a visiting examiner for the Primary FRCS exam.

It was in 1967 that Dr. Nihal Markus proceeded to England for postgraduate studies as a Commonwealth Scholar. In UK at the Royal Infirmary, Edinburgh under Prof. Strong he had a special training in Gastroenterology under the famous Professor Circu. He returned to his motherland, but was not fortunate enough to have the specialty recognized. Nevertheless, he practiced and taught

Gastroenterology wherever he worked – be it Trincomalee, Ratnapura, Negombo & Galle.

In 1973, Prof Dayasiri Fernando, having trained in Gastrointestinal Surgery under the guidance of giants in the field like Prof. John Goligher at University, department of Surgery (Leeds) returned to Sri Lanka & started practicing GI Surgery. He left for the U.K. again in 1976, after being awarded the Smith and Nephew Fellowship for training in Gastrointestinal surgery. He returned to Sri Lanka in 1977 full of enthusiasm and with a vision to establish Gastroenterology as a specialty in this country

But he was confronted with a very firm ‘No’ from a very hostile bureaucracy – the same barrier Dr. Nihal Markus faced. To them it was – “What is gastroenterology? No, it’s not important.”

However, those who had vision, like Dr Malinda Fernando and Dr Joe Fernando, two top level administrators at the time, together with Dr Upali Amarasuriya, the then Medical Superintendent of Kalubowila Hospital helped them enormously, when Gastroenterology was struggling to be born in this country.

At that time the facilities for diagnosis and treatment were minimal. Gastrointestinal imaging was very limited. Barium meal and screening, barium enema, cholecystogram, I.V. cholangiogram (with all its complications) and intra operative cholangiograms were the order of the day. There was no ultra sound scanning available.

In 1981, again after much persuasion, the first gastroduodenoscope (end viewing) was brought to this country – a big step forward. We could now view with accuracy the lumen of the upper G.I tract, take biopsies and take photographs using the Endoscope. It was a fiber optic endoscope and did not have a separate endoscopy room to house it. So, the Endoscopies were done in the corridor of the operating theatre – a make shift arrangement.

In 1983 the Gastroenterology unit was shifted to the Colombo General Hospital. At Prof Dayasiri Fernando’s request the PGIM created an Endoscopy unit in the University Department of Surgery, where he was appointed to be in charge. The Chairman of the Nawaloka Group of Hospitals agreed to build a small unit attached to ward 18. The Minister of Health declared this open on the 10th of May 1984. This was the first separate Endoscopy unit of the General Hospital Colombo. An-

other slimmer endoscope was donated by well wishers from Japan and it was used on children, gingerly moving onto sclerotherapy of oesophageal varices of both adults and children.

At about the same time, in 1985, Sri Jayewardenepura hospital started endoscopy and Dr. N. S. Jayasinghe and Dr. Yoheswaram were sent on a Japanese government scholarship for training in ERCP and colonoscopy. On their return Dr. Jayasinghe started ERCP for the first time in Sri Lanka. In December 1986, Dr Gamini Buthpitiya was the first to do a colonoscopy in the country at the Teaching Hospital, Peradeniya, using his personal colonoscope.

Teaching of Gastroenterology began at this stage with the Post Graduate Institute of Medicine, Sri Lanka Medical Association and the College of Physicians arranging special lectures.

In 1986, Dr. Nihal Markus was called back to his creator and eternal rest. In 1988 Prof. Dayasiri Fernando with the blessings of his teachers and senior colleagues and with the help of a group of keen and enthusiastic young doctors saw the birth of the new Gastroenterology and Digestive Endoscopy Society of Sri Lanka. He was elected the President and Prof. Janaka de Silva held the post of the secretary. Dr. P.T. de Silva, Vice President of the Society, delivered the inaugural Nihal Markus oration.

Within a short period of time the Society was accepted and elected to the governing councils of both the Asia Pacific Society of Gastroenterology and the Asia Pacific society of Digestive Endoscopy. The society was also elected to the ethics committee and the minimally invasive surgery committee of the World Organization of Gastroenterology. Money was required to maintain our membership and as our finances were limited, the Japanese Society of Gastroenterology paid our subscriptions for many years, as a friendly gesture, to a developing sister society. A few years later, the Society was rewarded with the decision of the governing councils to hold a mini congress of Asia Pacific in Sri Lanka. This was done amidst turbulence in the country and the bombing of the Kolonnawa oil tanks. The Chief Guest on this occasion was the Prime Minister, late Sirimavo Bandaranaike and the guest of honour was Minister of Justice Prof. G. L. Peiris. Another important activity that was orga-

nized was the Joint Academic Sessions with the College of Surgeons of Sri Lanka.

The specialty of Gastroenterology (Surgical) was approved for training by the PGIM in 1990, thanks to the untiring efforts of Prof. Dayasiri Fernando. Thereafter, having completed training, Dr. Nandadeva Samarasekara became the first to be board certified as a Gastrointestinal surgeon in Sri Lanka.

The year 1990 also witnessed significant advances in the field of GI surgery. With a personal gift of a stapling device from the American Embassy, the anastomosis of bowel in low anterior resection began. Another milestone was when Dr. K. L. Fernando did the first laparoscopic cholecystectomy in 1992, using his own instrument, at the Teaching Hospital, Ragama. This was a giant step forward for G.I. surgery. The department of surgery, University of Colombo were not far behind after purchasing a laparoscope with donations from friends and well-wishers. This was then followed by laparoscopic cholecystectomy at the Teaching Hospital, Kandy in 1998.

In 1999, due to the untiring efforts of Prof. Janaka de Silva, the PGIM approved Gastroenterology as a medical subspecialty and the following year Dr. N.M.M. Nawaratne became the first trainee under Prof. Janaka de Silva. He was later board

certified as the first gastroenterologist in the country in 2003 and was appointed to the National Hospital, Colombo.

In 2008, a proposal was put forward to rename the Society as the Sri Lanka Society of Gastroenterology and this was adopted at the AGM in 2011. In 2010 the first successful liver transplant was performed by the department of surgery, University of Colombo, thus providing an option for patients with end stage liver disease. The following year under the leadership of Prof. Janaka de Silva, North Colombo Teaching Hospital, Ragama followed suit.

By the end of 2020, the PGIM of the University of Colombo had produced 24 board certified gastroenterologists and 23 GI surgeons. These specialists have been appointed to all Teaching and Provincial hospitals and are now being appointed to general hospitals as well, thus giving island wide Gastroenterology services to the patients.

In future the medical and surgical divisions of the Gastroenterology in this country will most likely advance further in to sub specialties like hepatology, paediatric gastroenterology, colorectal surgery, hepatobiliary surgery and upper GI Surgery. At the core of this vision, the Society will endeavour to improve the knowledge and skills of the membership and continue to improve the quality



of work in the field of Gastroenterology in Sri Lanka.

**Compiled by Dr. Amal Priyantha**

# Resuming endoscopy services Post-COVID-19: Sri Lanka Society of Gastroenterology (SLSG) guideline for gastrointestinal endoscopy units

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*This guideline addresses the following issues:*

- Protection of health care workers (HCWs) and patients from cross infection during endoscopic procedures
- Reduction morbidity and mortality of patients who need endoscopic interventions, but have the procedures delayed during novel corona virus 2019 (COVID-19) pandemic
- Rational and cost-effective use for personal protective equipment (PPE) for the HCWs in resource-limited settings

*These guidelines may change with the evolution of the pandemic and prevailing epidemiological situation in Sri Lanka. It's applicability to individual institutions may vary depending on the availability of expertise, PPEs and other facilities and risk of COVID-19 infection in the catchment area.*

## Introduction

Severe acute respiratory syndrome corona virus 2 (SARS-CoV-2) can be transmitted during an endoscopic procedure via the following mechanisms:

1. Direct spread from person-to person via respiratory droplets
2. Inhalation of aerosols generated during endoscopy procedures
3. Indirect spread from contact with contaminated surfaces and body fluids and secretions<sup>1</sup>

### Patients and accompanying persons

Limit accompanying persons to one escort per patient.

Patients who are capable of attending to their needs independently should be encouraged to come alone.

All patients and persons accompanying patients should wear face masks and should complete the screening questionnaire before entering the endoscopy unit.

Temperature check of patients and accompanying persons by infra-red digital thermometer is encouraged

Those classified as intermediate and high risk (Table 1) should additionally wear gloves

Patient should be educated on how to keep the mask safely without getting contaminated while going through a gastroscopy

Patient can keep the mask on if colonoscopy is done under conscious sedation and oxygen saturation can be maintained above 93%.



### **Modifications of the structure and functioning of the Endoscopy Unit**

Standard facilities for hand washing and hand sanitizers should be available in endoscopy unit for the staff, patients and accompanying persons.

At least 1m distance between two persons should be maintained while awaiting the procedure.

Patients should be given timed appointments to prevent overcrowding of the waiting area.

When facilities available, a hospital supplied overall should be given to all patients attending procedures.

Between procedures all high contact areas and all horizontal surfaces should be cleaned with a hospital grade disinfectant.

Mop and clean the procedure room, recovery area and waiting area at least 2-3 times a day in addition to terminal cleaning at the end of the day.

If a procedure is performed on a high risk patient, immediate disinfection of the room is required.

Standard high level disinfection as per the manufacturer's recommendation is adequate for scope cleaning and reprocessing and no special adaptation is required.

### **For the staff of endoscopy unit**

Self-monitoring and reporting of symptoms and signs of COVID-19 infection should be encouraged among all HCWs.

In addition, it is preferable to screen all HCWs for symptoms and signs of COVID-19 infection before each session of endoscopy. This can be done for nursing and supportive staff by the nurse-in-charge and for doctors by the consultant or a senior medical officer of the unit.

Daily temperature check of HCWs by infra-red digital thermometer is encouraged.

All staff entering the endoscopy unit should wear face masks.

Wear boots or equivalent foot wear when entering the endoscopy unit and remove on exit

Avoid bringing stethoscopes, mobile phones etc. into the procedure room as they can get contaminated. If you are on call, use a Bluetooth ear phone to answer calls and keep the mobile phone in a place which unlikely to be contaminated.

Minimize the number of persons inside the room. Allow only the essential staff to be inside the procedure area.

Review and determine the appropriateness of the involvement of the trainees in endoscopy considering procedure time and PPE supply.

Assigning a single task throughout the endoscopy session for each staff member is recommended.

Consider teams (doctors, nurses, minor staff members, radiographers) that remain together for the entire day in order to compartmentalize and minimize exposure.

A significant percentage of patients infected with COVID-19 have gastrointestinal symptoms such as anorexia, diarrhea and vomiting and occasionally can present initially or solely with gastrointestinal symptoms. COVID-19 virus can be present in stools of infected patients and can be potentially spread by fecal material<sup>1,2,3</sup>.

## Recommendations

All major hospitals in Sri Lanka have screening questionnaires to assess the risk of COVID-19 among patients presenting for evaluation or treatment. We advise to adhere to the local protocol to assess the probability of COVID-19 in patients before scheduling endoscopy.

### Recommendation of manpower for endoscopic procedures

In order to reduce the risk of concomitant exposure and for efficient use of PPEs only the essential staff members should be present inside the active endoscopy room.

For example:

- a. UGIE/LGIE: 1 or 2 doctors, 02 nurses and 01 minor staff member
- b. ERCP: 1 or 2 Endoscopists, 01 Aneasthetist , 02 nurses, 01 minor staff member and 01 radiographer

Care givers/relatives should be strictly prohibited from entering the endoscopy areas unless there is a valid reason

### Classification of potential SARS-CoV-2 infection risk and rational use of personal protective equipment

\*In an emergency setting all procedures must be considered high risk if adequate patient history cannot be assessed

<b>Low risk</b>	No suggestive symptoms (Eg: Cough, Fever, Breathlessness, Diarrhea) No contact with someone with SARS- CoV 2 rRT-PCR positive Non stay in high risk area during the previous 14 days
<b>Intermediate risk</b>	Presence of suggestive symptoms with: <ul style="list-style-type: none"><li>· No medical history for contact with someone with SARS-CoV-2 positive</li><li>· Non stay in high risk area during the previous 14 days</li></ul> No symptoms but <ul style="list-style-type: none"><li>· Contact with someone with SARS-CoV-2 rRT-PCR positive</li><li>· Stay in high risk areas during the previous 14 days</li></ul>
<b>High risk</b>	At least one symptom plus one of the following <ul style="list-style-type: none"><li>· Contact with someone having SARS-CoV-2 rRT-PCR positive</li><li>· Stay in a high risk area during the previous 14 days</li></ul>

**Table 1: Classification of potential SARS-CoV-2 infection risk in patients undergoing endoscopy procedures** (Adopted from Gralnek IM et al. *Endoscopy*.2020: <https://doi.org/10.1055/a-1155-6229>)

Risk classification	PPE ( to be worn in following order)
Low risk	<ol style="list-style-type: none"> <li>1. Hair net</li> <li>2. Wash hands</li> <li>3. Single use gowns (AAMI level 1) (Lead wear for fluoroscopy to be worn underneath the gown)</li> <li>4. Surgical masks</li> <li>5. Goggles or face shield</li> <li>6. Gloves</li> </ol>
Intermediate/High risk	<ol style="list-style-type: none"> <li>1. Hair net</li> <li>2. Wash hands</li> <li>3. Long sleeved water resistant gowns (AAMI level 3) (Lead wear for fluoroscopy to be worn underneath the gown)</li> <li>4. N95 or equivalent mask</li> <li>5. Goggles or face shield</li> <li>6. Two pairs of gloves</li> </ol>

Table 2. Guide for using personal protective equipment during endoscopy<sup>4</sup>

**Removal of PPE: (in the following order)**

Gloves (1<sup>st</sup> pair only if double gloves worn), Hand wash and wear new pair of gloves, Gown, Goggles (do not touch the front), Mask (do not touch the front of the mask), Hair net, Last pair of gloves

Following cartoon depicts donning and doffing of PPE for intermediate and high risk patients



Urgent	Semi urgent	Elective
Acute Upper GI Bleeding	Suspected Cancers	All other routine diagnostic endoscopies
Foreign body removal	Biliary drainage of Hepato-biliary Cancers	Cirrhosis – variceal screening
GI access to urgent feeding	Endoscopy and ERCP for treatment of GI/hepatobiliary/pancreatic neoplasia	ERCP for non-malignant conditions – non obstructed stones, chronic pancreatitis
Management of perforation and leaks	Enteroscopy for GI bleeding	Diagnostic EUS
Biliary sepsis	Cirrhosis - post-EVL surveillance	GI malignancy surveillance endoscopies
GI obstruction requiring stents		Endoscopy therapy for non-malignant conditions: POEM, GERD, ESG
Suspected IBD presenting with acute flare		All surveillance and follow up endoscopy – Barrett oesophagus, Polyps, IBD, positive occult blood, history of GI cancer

**Table 3: Endoscopy procedures can be classified as urgent/semi urgent and elective.** (Adopted and modified from Chiu PWY, et al. *Gut* 2020; 0:1–6. doi:10.1136/gutjnl-2020-321185)

COVID-19 in the community	PPE supply	Endoscopy service
Exponential increase in new cases	Critical (reserve <7 days)	<ul style="list-style-type: none"> <li>Urgent Endoscopy only</li> <li>Withhold semi urgent and elective</li> </ul>
Rapid increase in new cases	Very Low (reserve <4weeks)	<ul style="list-style-type: none"> <li>Urgent Endoscopy only</li> <li>Semi urgent endoscopy – to be individualized</li> <li>Withhold elective endoscopy</li> </ul>
Downward trend in new cases	Sub optimal (reserve 4-8 weeks)	<ul style="list-style-type: none"> <li>Urgent Endoscopy – Full capacity</li> <li>Semi Urgent Endoscopy – Full capacity</li> <li>Elective Endoscopy – Resume with 50% capacity</li> </ul>
No new cases of COVID 19 for last 2 weeks	Normal (12 weeks reserve )	<ul style="list-style-type: none"> <li>Urgent Endoscopy - Full capacity</li> <li>Semi urgent Endoscopy Full capacity</li> <li>Elective Endoscopy Full capacity</li> </ul>

**Table 4: Provision of endoscopy services during COVID-19 pandemic** (Adopted from Gralnek IM et al.

## Provision of endoscopy services during COVID 19 pandemic

Provision of endoscopy services during COVID-19 pandemic would depend on the following factors:

- Number of active COVID-19 patients reported in the area
- Availability of medical equipment and PPEs
- Morbidity and mortality related to postponement of endoscopic procedures

Above factors should be continuously reviewed to decide on the level of endoscopy service provision. The table 4 is a guide to decision making

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# A n Update on NAFLD

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Nonalcoholic fatty liver disease (NAFLD) is rapidly becoming the most important cause for cirrhosis and hepato-cellular carcinoma worldwide. Nearly a third of the world population has NAFLD. About one in ten of these should be having the progressive form of the disease which leads to cirrhosis and HCC. Therefore, we can expect to have an epidemic of NAFLD related cirrhosis in the future. Energy excess, lipotoxicity, GUT dysbiosis and the genetic susceptibility are the main underlying mechanisms of the progressive form of the illness.

NAFLD is closely related to the other metabolic illnesses like diabetes mellitus, obesity and hyperlipidemia and a change of its nomenclature to metabolic associated liver disease (MAFLD) is under consideration. Cardiovascular causes are mainly responsible for the mortality in NAFLD. Liver related mortality is only encountered in patients with the progressive form of the disease. The stage of liver fibrosis predicts the mortality from liver related outcomes in NAFLD. Therefore, it is very important to diagnosed advanced fibrosis early to initiate useful interventions. Due to this, patients with NAFLD need to be screened for evidence of advanced fibrosis regularly.

Advancing age and the presence of components of the metabolic syndrome are the principle risk factors for advanced fibrosis. There is evidence to suggest that 1 in 5 middle aged diabetics with fatty liver have the advanced fibrosis. FIB-4 score and the NAFLD fibrosis score (NFS) are simple calculations available widely to exclude advanced fibrosis at a primary care level. These calculations are available online free of charge, are reliable and the investigation parameters used are not costly. The age, AST, ALT and the platelet count are used in the calculation of the FIB 4 score. If advanced fibrosis is present or the results are inconclusive, these patients need liver stiffness measurement (LSM/Elastography/Fibroscan) to assess the staging of fibrosis. If the LSM is >8Kpa the patient should

be further evaluated with a liver biopsy and started on liver directed therapy. If the LSM is <8 kPa the patient should have a repeat FIB4 score every year with the initiation of lifestyle interventions.

Weight loss is the mainstay of treatment in progressive NAFLD but is difficult to achieve and sustain. Significant weight loss (>10%) reverses fibrosis but is a difficult task. Even lesser degrees of weight loss have beneficial effects on the histology. Calorie deficit and healthy eating habits should be encouraged. Fast foods and foods containing added fructose should be discouraged.

Pharmaceutical interventions are reserved for the patients with progressive form of the illness. Vitamin E & pioglitazone which is useful in patients with inflammation (NASH) can be considered but still not licensed to be used liberally. Obeticholic acid has shown benefits in reversing fibrosis stage but has not yet been recommended or approved. Saroglitazar, a diabetic drug which is licensed in India for NASH is first drug ever to be approved for this indication in the world. Other metabolic issues like diabetes, hypertension and hyperlipidaemia should be managed optimally.

Smoking and alcohol should be discouraged. Coffee intake is considered beneficial. All forms of exercise are beneficial and should be encouraged.

Use of statins is to be encouraged as per guidelines on hypelipidaemia as most of these patients have an indication for a statin. This is very important as cardiovascular causes are main reason for mortality in patients with NAFLD. Statins also appear to be beneficial across the spectrum of progressive NAFLD up to the development of hepatocellular carcinoma. ●

# Laparoscopic cholecystectomy in acute mild gallstone pancreatitis: how early is safe?

Guiffrida P et al. *Updates in Surgery*(2020)

<https://doi.org/10.1007/s13304-020-00714-9>

## Reviewed by:

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The surgical strategy to resolve the underlying biliary pathology in patients with acute gallstone pancreatitis (AGP) remains controversial. The aim of this study was to evaluate the safety and effectiveness of early laparoscopic cholecystectomy (ELC) in patients with mild AGP. A retrospective cohort of consecutive patients diagnosed with mild AGP according to the Atlanta Guidelines from January 2009 to July 2019 was selected. Patients were assigned to surgery on the first available surgical shift, 48 h after the symptom's onset. Univariate analysis was performed to determine the association between AGP and grades of Balthazar (A, B and C) with time to surgery, days of hospitalization and postoperative complications. From 239 patients evaluated, 238 (99.58%) were operated by laparoscopic approach. Intraoperative cholangiogram was performed routinely. Choledocholithiasis, if present, was successfully treated by laparoscopic common bile duct exploration in all cases. A significant association was found between Balthazar grades and time to surgery (median of 3 days,  $p=0.003$ ), with length hospitalization and from surgery to discharge, with median of 4 days ( $p=0.0001$ ) and 2 days ( $p=0.003$ ), respectively. Mild postoperative complications (CD I/II) were observed in 22/239 patients (9.2%). This represents 2% of patients with grade A of Balthazar, 9% of grade B and 14% of grade C ( $p=0.016$ ). We observed no severe complications or mortality. ELC with routine intraoperative cholangiogram, performed on the first available surgical shift 48 h after the symptoms of pancreatitis onset, is a viable, effective, and safe strategy for the resolution

of mild AGP and its underlying biliary pathology in a single procedure.

## Comment

The authors performed a retrospective analysis to study the safety of early laparoscopic cholecystectomy in patients with mild gallstone pancreatitis. Patients without SIRS underwent contrast CT of the abdomen and intraoperative trans cystic cholangiogram. In 99.58% of patient's surgery was completed with laparoscopic approach with only 9.2% developing mild complications, therefore reducing the chances of recurrent admissions with gallstone pancreatitis and establishing the safety of early laparoscopic cholecystectomy.

However, the retrospective nature of the study limits its validity due to possible selection bias.

In the Sri Lankan setting where intraoperative cholangiogram is not commonly performed, early laparoscopic cholecystectomy may warrant a contrast CT of the abdomen as well as a MRCP scan in 48 hours from admission limiting its practicality in a resource-poor setting.

24.6% of the patients needed laparoscopic choledocholithotomy. Therefore, early laparoscopic cholecystectomy should be contemplated by surgeons with advanced laparoscopic skills. ●

# Is Metformin Safe for Patients with Cirrhosis?

Kaplan DE et al. *Clinical Gastroenterology and Hepatology* (2020)

doi: <https://doi.org/10.1016/j.cgh.2020.08.026>.

## Reviewed by:

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**Consultant Gastroenterologist and Hepatologist**  
**TH Batticaloa**

Patients with cirrhosis and diabetes are co-administered multiple medications including metformin and statins. Type 2 Diabetes is also a poor prognostic factor in patients with cirrhosis. Metformin in particular is a very well-established, yet (unfairly) vilified antidiabetic drug in patients with co-morbidities. The aim of this study was to assess the impact of metformin exposure on mortality, hepatic decompensation, and [hepatocellular carcinoma](#) in individuals with diabetes and cirrhosis. The probable confounding factors/exposures, such as the use of statins, angiotensinogen-converting enzyme inhibitors (ACEI) or angiotensin-2-receptor blockers (A2RB) were also considered.

This was a retrospective cohort study on a sample of patients with cirrhosis diagnosed between January 1, 2008, through June 30, 2016, in the Veterans Health administration. Special statistical methods were used to quantify the treatment effect of metformin in patients with pre-existing diabetes with or without prior metformin exposure.

Out of 74,984 eligible patients, 53.8% was known to have diabetes prior to the diagnosis of cirrhosis. A further 4.8% was diagnosed with diabetes subsequently. 11,114 patients were using metformin prior to the diagnosis of cirrhosis. In this group of patients, the use of metformin, statin, as well as ACEI/A2RB blocker were all independently associated with reduced mortality (metformin HR 0.68 95%CI 0.61-0.75). In patients with a prior diag-

nosis of diabetes who were not previously exposed to metformin, the addition of the drug was also noted to have a reduction in mortality (HR 0.72 95%CI 0.35-0.97). Child-Turcotte-Pugh (CTP) A and B (but not C) patients appeared to benefit. After adjusting for the concomitant use of statins, there was no significant reduction in the risk of hepatocellular carcinoma or hepatic decompensation by metformin in both the above categories.

The authors concluded that “metformin use in patients with cirrhosis and diabetes appears safe and is independently associated with reduced overall but not liver-related mortality, hepatocellular carcinoma or decompensation after adjusting for concomitant statin and ACEI/A2RB exposure.”

- These results reinforce the fact that metformin is a safe and effective drug when appropriately used in patients with cirrhosis and diabetes.
- Although the proportional representation of CTP class C patients was less in this study, it is advisable to be carefully weigh the risk: benefit ratio in such individuals before deciding to use metformin.
- Contrasting to some previous studies, no significant independent effect of metformin on the reduction of hepatocellular carcinoma was observed. ●

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# A Alcohol use as a Disorder and a Risk factor

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Consuming alcohol is one of the key behavioral risk factors for morbidity and mortality. The cost of the alcohol-related conditions was USD 885.86 million or 1.07% of the GDP for Sri Lanka in 2015.

The health impact of alcohol use is seen equally or more among others ("second hand" effects) than the users. This unique feature is not shared by any other substance of misuse.

An example would be an alcohol user who is having liver damage, driving a motor vehicle under the influence of alcohol, injuring a pedestrian or an individual with alcohol dependence engaging in domestic violence resultant adverse psychological impact on family.

The effects of alcohol are not limited to the higher end of use, but present throughout the spectrum of use. This observation makes it necessary that interventions targeting whole spectrum of alcohol use, not only dependent drinkers.

For example the risks estimated for low level of consumption is considerable, with one drink a day (defined as 10g of pure alcohol) increasing the risk of developing an alcohol-related disease including cancer, diabetes and tuberculosis by 0.5 per cent. This rises to 7 percent for two drinks a day, and 37 percent for five drinks per day.

The approach to address the burden of disease due to alcohol should include individual, community, and population-level strategies simultaneously. This can create a comprehensive response at all levels.

While evidence-based, individual-level strategies (e.g. screening, brief intervention at all levels

of health care and referral to specialist treatment when needed) are an important component of a comprehensive effort, population-level interventions should not be forgotten as they offer greater protection for more people at less cost.

Medical practitioners need to get a few unhelpful thinking errors corrected as well. We must get rid of the idea that alcohol problems are created mostly by a small group of alcohol dependent individuals who require medical or mental health treatment.

Doctors should support and be active in full implementation of well-established public health interventions and ineffective strategies like education of the public about should not get the whole emphasis.

In the treatment settings, the approach should be to universally screen for any alcohol use, not only for so called "problem use". Screening instruments like Alcohol Use Identification Test (AUDIT) have been validated for local use.

The only way to avoid the health risks associated with alcohol is giving up drinking entirely. Concepts like low risk drinking or healthy drinking have been clearly shown to be false in global burden of disease studies.

It is known that a medical practitioners concern about a patient's alcohol use itself can reduce the use with considerable health benefits. This fact makes addressing alcohol problems every doctor's responsibility. ●

# Laparoscopic cholecystectomy for acute cholecystitis: is the surgery still safe beyond the 7 day barrier?

Di Martino et al, *Updates Surg* (2020).

<https://doi.org/10.1007/s13304-020-00924-1>

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Several prospective studies have demonstrated that indexed admission laparoscopic cholecystectomy (ELC) for acute cholecystitis (AC) is safe when compared with delayed LC(DLC) in terms of morbidity, shorter length of stay (LOS), minimizing costs and risk of relapse. There is still controversy regarding the indication of ELC in patients with severe inflammation of the gallbladder, and the optimal timing of surgery after the clinical debut of AC remains debatable. The 'golden 72-hour rule' from symptom onset was proposed as a safe period for the timing of ELC, according to Tokyo Guidelines 2013. With increased experience in advanced laparoscopic surgery, finally, for the first time, the Tokyo Guidelines 2018 proposed ELC for patients who can tolerate surgery regardless of the symptom duration.

This is the largest series assessing outcomes of ELC in patients (n=1868) with AC with more than one week of symptom duration. The aim of this multi-center retrospective observational study was to assess the outcomes of ELC beyond the first 7 days of symptoms.

According to this study, in general, ELC beyond 7 days was associated with an increased rate of conversion to open surgery ( $p = 0.004$ ), overall intraoperative complications ( $p = 0.001$ ) and intraoperative bleeding  $> 500$  ml ( $p = 0.001$ ), without significant differences in operative time or bile duct injury. LC beyond 7days was associated with increased number of overall postoperative complications within the first 30 days ( $p = 0.011$ ), raised the rate of postoperative haemorrhage ( $p < 0.001$ ), global infectious complications ( $p = 0.003$ ). Furthermore, it also associated with an increased duration of the antibiotic therapy (AT) ( $p < 0.001$ ) and total LOS ( $p < 0.001$ ) without significant differences in

postoperative AT, postoperative LOS or readmission rate. In Comparison of low volume centers (LVC) vs higher volume centers (HVC) showed that HVC presented an increased operative time ( $p < 0.001$ ), but a decreased rate of conversion to open surgery ( $p < 0.001$ ), a higher percentage of procedures and decreased intraoperative bleeding ( $p = 0.047$ ). Postoperatively, HVC accounted for significantly decreased overall complications such as bile leakage, global infectious complications ( $p = 0.020$ ), surgical site infections, shorter duration of global antibiotic treatment and LOS.

## Comments

- In the Sri Lankan setting most laparoscopic cholecystectomies for acute cholecystitis is performed as an interval procedure 6 weeks' after the initial presentation.
- The study authors performed a retrospective review, and this increases the possibility of potential selection bias.
- Early LC must be indicated cautiously in patients with AC and more than 1 week of symptom duration, as it was associated with higher perioperative morbidity.
- Perioperative complications were generally higher in low volume centers which were mainly responsible of the increased perioperative morbidity of ELC performed in ACC with  $> 7$  days of symptoms.
- Therefore, early LC for AC with  $> 7$  days of symptoms should be performed in centers that have sufficient experience in the management of the disease. ●

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18 <sup>TH</sup> APRIL 2021	5.00 PM – 6.00 PM	CHRONIC NAUSEA & VOMITING: A DIAGNOSTIC APPROACH	<b>PROF MADUNIL NIRIELLA</b> MBBS(Col). MD(Col), FRCP(Lon), MRCP(UK), Professor in Gastroenterology Department of Medicine Faculty of Medicine University of Kelaniya
20 <sup>TH</sup> JUNE 2021	5.00 PM – 6.00 PM	TIPS & TRICKS IN ERCP	<b>DR MOHAN RAMCHANDANI</b> MBBS, MD, DM consultant gastroenterologist and Director interventional Endoscopy, AIG Hospitals, India
18 <sup>TH</sup> JULY 2021	5.00 PM – 6.00 PM	BASICS OF ENTERAL / PARENTERAL NUTRITION	<b>DR THIMATHY WICKRAMASEKARA</b> MBBS MSc (Human Nutrition)MD (clinical nutrition)Advance Clinical Nutrition Fellowships UK
15 <sup>TH</sup> AUGUST 2021	5.00 PM – 6.00 PM	FUNCTIONAL PROCTOLOGY - CONSTIPATION & INCONTINENCE	<b>PROF NANDADEVA SAMARASEKARA</b> MBBS(Col.), MS(Col.), FRCS(Eng), FRCS(Edin) , MD by thesis(UK), PG Cert Med Ed(Dundee), Senior Professor & Chair of Surgery Department of Surgery Faculty of Medicine, University of Colombo
19 <sup>TH</sup> SEPTEMBER 2021	5.00 PM – 6.00 PM	ACUTE LIVER FAILURE IN CHILDREN	<b>DR MERANTHI FERNANDO</b> MBBS (Kelaniya), DCH (Col), MD-Paed (Col), MRCPCH (UK), Senior Lecturer department of Pediatrics, University of Kelaniya, Consultant Pediatrician – CNTH
17 <sup>TH</sup> OCTOBER 2021	5.00 PM – 6.00 PM	GERD TREATMENT - ENDOSCOPIC THERAPY Vs SURGERY	<b>DR NILESH FERNADOPULLE</b> MBBS(Col), MD(Col), Sp. cert. in Gastroenterology(UK), Consultant Gastroenterologist, Senior Lecturer department of Surgery Faculty of Medicine, University of Colombo <b>DR CHATHURANGA KEPPETIYAGAMA</b> MBBS, MD ( Surgery), MRCS (Eng), FAMS India), Consultant Gastroenterological Surgeon, NH Kandy
19 <sup>TH</sup> DECEMBER 2021	5.00 PM – 6.00 PM	PERIOPERATIVE MANAGEMENT OF CLCD	<b>DR BHAGYA GUNATHILAKE</b> MBBS (Col), MS (Anaes(Col), FRCA (UK), Senior Lecturer in Anesthesiology Department of surgery Faculty of Medicine University of Kelaniya

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