Methods This is a prospective observational study of patients with opioid abuse, who were diagnosed as having GI ulcers or strictures, between January 2016 and December 2018, at Dayanand Medical College and Hospital, Ludhiana, India. The diagnosis was made on the basis of radiology (Computed Tomography Enterography or Magnetic Resonance Enterography) and/or endoscopy (gastroduodenoscopy or ileocolonoscopy). The ulcer/stricture was attributed to opioids once other possible etiologies of GI stricture like non-steroidal anti-inflammatory drugs, Crohn’s disease, infections, neoplasias, corrosive ingestion, ischaemia and peptic ulcers were excluded. Clinical parameters including presenting complaints, site of disease, haematological and biochemical parameters and treatment given were recorded.

Results During the study period, 18 patients (mean age 38.46 ±14.86 years, 100% males) were diagnosed to have opioid-induced GI ulcers/strictures. Tramadol capsules (77.78%) followed by poppy husk (22.22%) were the most common forms of opioid consumption. Iron deficiency anaemia [n=16 (88.89%)], fatigue [n= 14 (77.78%)], vomiting [n=11 (61.11%)], pain abdomen and loss of weight [n=10 (55.55%) each] were the most common presenting complaints. Five (27.78%) patients presented with GI bleed. There were two common sites of involvement, gastroduodenal (n=11, 61.11%) and jeuno-ileal (n=7, 38.89%). Four (22.22%) patients had ulcers whereas 14 (77.78%) patients had strictures on evaluation. Ten (55.55%) patients underwent balloon dilatation of stricture, six of whom (60%) failed to respond and needed surgical intervention. Two patients (11.11%) were taken up for emergency surgery (without attempting balloon dilatation) as both had deep Forrest IA duodenal ulcers, refractory to endoscopic management. Results are summarized in table 1 (table 1).

Conclusions Opioid abusers can have gastro-intestinal ulcers and strictures and are difficult to treat with medical/endoscopic therapy.

Abstract IDDF2019-ABS-0310 Figure 1

Conclusions With serial colonoscopic FMTs for active ulcerative colitis, the response rates, determined by the maintenance of steroid-free clinical remission and endoscopic remission, gradually increase. Repeated interventions over longer periods may result in a persistent change in gut microbiota composition that is otherwise inherently resilient, resulting in improvement in disease activity indices.

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Efficacy and cost-effectiveness of premedication with N-acetylcysteine during upper gastrointestinal endoscopy examination: a single center, prospective, single blinded, randomized controlled trial

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Background Detecting gastric cancer in the early stage is the key factor in reducing cancer mortality. Endoscopists can now detect early cancer with the aid of advanced imaging in endoscopy. A major technical obstacle in achieving a good quality of endoscopic examination of the gastric mucosa is the presence of foam and mucus over the mucosal surface. Pro-nase has become a common anti-mucus agent used for improving visibility during upper gastrointestinal endoscopy examination, especially in eastern Asia. While N-acetylcysteine (NAC) can serve as an alternative mucolytic agent more economically. The aim of this study is to investigate the efficacy and cost-benefit of premedication with NAC during esophagogastroduodenoscopy (EGD).
Abstracts

Methods We enrolled 1,200 patients and randomly allocated them into 4 groups with different types of premedication. Premedication used in regular group (RG) was 10 mL lidocaine hydrochloride mucilage (LHM) and in pronase+simethicone group (P+S) was 60 mL pronase/simethicone solution plus 10 mL LHM. Meanwhile, 60 mL NAC600 mg/simethicone solution plus 10 mL LHM and 60 mL NAC1200 mg/simethicone solution plus 10 mL LHM were given to the patients in NAC600+simethicone group (NAC600+S) and NAC1200+simethicone group (NAC1200+S), respectively. We recorded visibility scores, times of cleaning, time taken for examination, diminutive lesions and pathological diagnosis. Cost-benefit of premedication was analyzed.

Results The visibility of NAC600+S and NAC1200+S are significantly better than RG, although P+S exhibited the lowest total visibility score and shortest procedure duration (figure 1). Times of cleaning was remarkably decreased in NAC600+S and NAC1200+S compared to RG, but was inferior to P+S. There is no significant difference in detection rate of diminutive lesions and pathological diagnosis. Cost-benefit analysis has shown that net medical yield of NAC/simethicone is higher than that of pronase/simethicone.

Conclusions NAC can not only facilitate the visibility during EGD, but be more cost-beneficial. It should be recommended as a good alternative premedication to pronase during EGD, especially in developing countries and regions.

Background Fecal microbiota transplantation (FMT) has emerged as a novel therapy for ulcerative colitis (UC). However patient selection in published trials is not uniform. Also, not all patients receiving FMT show a clinical response. Hence ideal patient population to be considered for FMT is not known. We study the factors affecting response to fecal microbiota transplantation in patients with active ulcerative colitis.

Methods This was a single-centre analysis of data from patients with active UC treated with FMT from September 2015 to December 2018 at the Dayanand Medical College, a tertiary care centre in India. Fecal samples from two unrelated donors [A and B, alternatively for each session (A.B.A.B.A.B.A)], were administered through colonoscopy at weeks 0, 2, 6, 10, 14, 18, and 22. Disease activity including endoscopic severity (using Mayo score) and response to therapy was assessed and recorded at each visit. Clinical response was defined as a decrease from baseline in mayoclinic score by ≥30% and ≥3 points with a decrease in rectal bleeding subscore of ≥1 or rectal bleeding subscore of 0 or 1. Both disease characteristics and patient characteristics affecting response to FMT were then retrospectively analysed.

Results One hundred twenty-four patients [mean age 34.84 ±11.91 years, 66.93% males (n=83), mean mayoclinic score 8.13 ± 2.65, mean disease duration 5.04 ± 4.82 years] who received FMT were analysed retrospectively. The characteristics favouring response to FMT were E2 disease (p=0.01) and severe disease (greater total mayoclinic score, endoscopic mayoclinic score, ESR and CRP; p= 0.001, 0.003, 0.002, 0.001 respectively). Low serum albumin was a predictor of non-response (p= 0.003). Patients with no pseudopolyps (p=0.06) and previous exposure to biologics (p=0.08) and thiopurines (p=0.06) showed a trend towards response with FMT, however, failed to reach statistical significance. Concomitant use of corticosteroids did not affect the response rates with FMT (p>0.05).

Conclusions Left-sided UC, severe disease and high serum inflammatory markers (ESR and CRP) significantly predict response to FMT. Absence of pseudopolyps and previous exposure to biologics and thiopurines also favoured response.

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