325

Gastroenterology & Nutrition

Coeliac Disease (CD) and Gastropathy in Paediatric Practice

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Background: Reactive gastropathy is a defensive change in the stomach. In adults, it is caused *inter alia* by NSAID use and bile reflux. Histological features of reactive gastropathy include foveolar hyperplasia, mucosal congestion and hyperplastic smooth muscle . Reactive gastropathy is associated with various inflammatory conditions.

Objective: The authors sought to characterise the association between reactive gastropathy and coeliac disease in children.

Methods: A retrospective chart review on paediatric gastroscopies conducted between 2003-2018 was used. The data was stored in Excel. All patients with coeliac disease or any gastropathy were identified by histopathology. The presence of gastropathy was noted in those with proven coeliac disease. The presence of bile in gastric contents was also recorded as this could act as a potential confounder.

Results: 1779 gastroscopes were reviewed. 1279 results were available for the histopathological diagnosis of the stomach. 437 had reactive gastropathy, a prevalence of 24%. Of those with reactive gastropathy, 143 had confirmed CD. 842 did not have gastropathy. Of this group, 149 had confirmed coeliac disease. Fisher's exact test showed a significant difference between the results (p0.05).

Of the 143 confirmed CD diagnoses within the gastropathy group, there were 81 cases of gastric contents recorded. In 231 cases recorded overall, there was no association between the presence of bile in the stomach and gastropathy. (NS using Fisher's exact test.) Overall 195 of 294 with CD recorded an abnormal gastric biopsy, 3 of them lymphocytic gastritis. 12 of 294 (4%) had eosinophilic oesophagitis (EoE).

Discussion: Gastropathy of various types is common at endoscopic pathology. Reactive gastropathy, distinct from lymphocytic gastritis, is common in CD in paediatrics, and EoE may also be more common than observed background rates. Bile stained gastric contents did not explain the gastropathy, and reactive gastropathy is not confined to CD patients.

997

Gastroenterology & Nutrition

Is This Caroli Disease?

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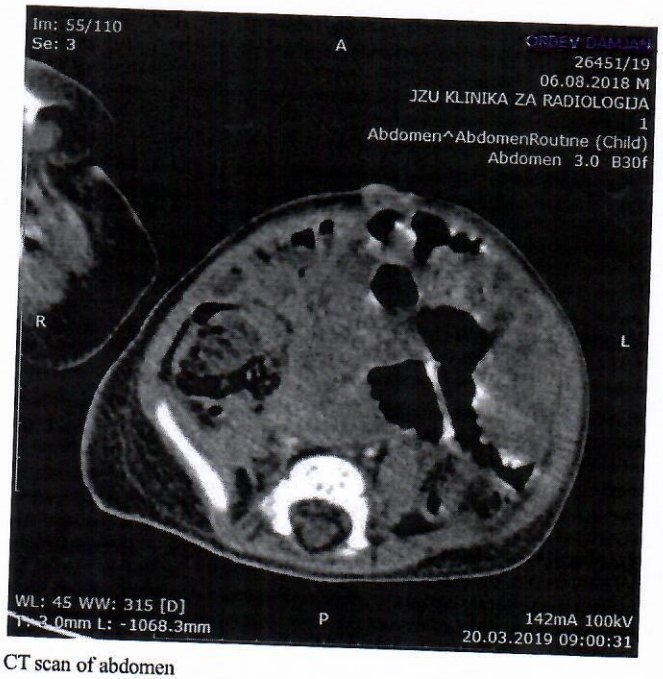
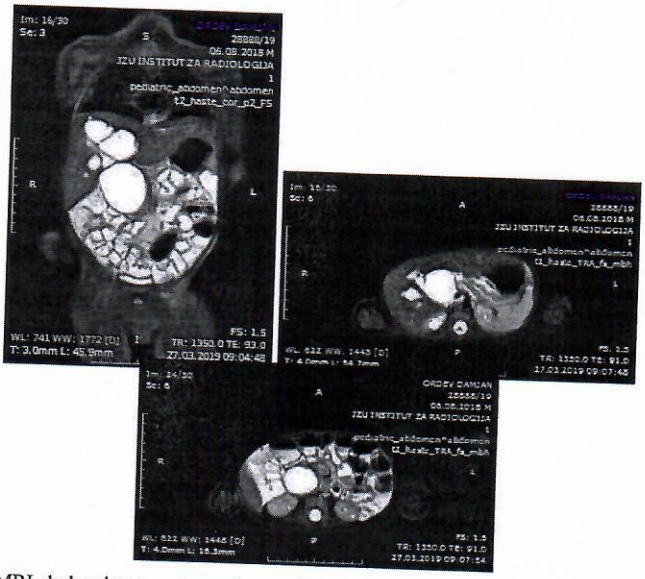
Introduction: Caroli disease is rare congenital disorder of the intrahepatic bile ducts. It is characterized by dilatation of intrahepatic biliary tree and with renal cysts. Caroli disease is inherited autosomal dominant.

Aim: To present a case of seven months old infant with icterus of the skin and sclera.

Material and methods: Seven month old infant with gray-yellow skin color and fatigue for a month. Positive family history of policystic renal disease and carcionama of the liver. At admittion afebrile, pale, yellow sclera. Abdomen above torax. On palpation with hepatosplenomegaly. From examinations: WBC -17,07 CRP= 12.9mg/l. Tot.Bill= 141,5umol/l, Dir. Bill= 93.3umol/l, AST= 142U/L, ALT= 143U/L, ALKP= 790 U/L, LDH= 415U/L, CK=330U/L, CA-19-9 =399,7 U/ml. Abdominal ultrasound showed more cystic formations in the liver that are connected in parts and a larger cyst in the hepatoiduodenal ligament and the liver hilus. The finding goes in addition to Caroli disease. CT scan of abdomen and MRI cholangiopancreatography showed hepatomegaly, cystic and sacular dilated intra and extrahepatic bile pathways. Both kidneys are without signs of obstruction, but with cortical cysts, right in the upper parts and left in the interpolar region with diameter 15 mm. Mild intestinal distension.



CT scan of abdomen



MRI cholangiopancreatography

Results: Child is outpatient followed by a Pediatric gastroenterohepatologyst and Pediatric surgeon. Child recives Ursodeoxycholic acid and the last results with withdrawl of liver enzymes and bilirubin. HLA typisation is planed for liver transplatation in the future.

Conclusion: Although this disease is rare, hyperbilirubinaemia of direct type and a positive familial history of polycystic kidney should lead us to think of Caroli disease.