JGLD at the changing of the guard

To the Editor,

An Editor-in-Chief's farewell was published in the latest issue of JGLD (December, 2017)[1], providing me with the opportunity to shortly evaluate what has been achieved during the past two decades, to assess where the Journal ranks at present among other gastroenterology/hepatology journals, and look optimistically to the future.

First, we, members of the Editorial Board, authors of the published articles and readers, wish to thank Professor Monica Acalovschi, our previous Editor-in-Chief, who, over the past 25 years has been the leader in making JGLD a great medical journal. Such a position is by no means an easy one, requiring extensive medical knowledge, high ethical standards, an enormous amount of time and effort, and, above all, the ability to remain impartial and honest. In addition to being a well-known gastroenterologist, Monica has a broad education and a true gift for working in public relations, which helped her greatly in running an important international medical journal such as JGLD. Her vision and commitment have turned an obscure, unknown journal into a respected one, earning it a well-deserved place among other journals specialized in digestive diseases. Thus, JGLD has had during these last years an exceptional performance by every measurable criterion. We are particularly proud of the improvement achieved in the Institute for Scientific Information (ISI) citation index for JGLD with a 2.135 Five-Year-Impact Factor in 2016, the Thomson Reuters Web of Knowledge Journal Citation Reports 2016 ranking 61/79 (gastroenterology and hepatology), as well as the SCImago Journal Ranking for 2016: 68/134 (gastroenterology)[2]. As we know, there is a huge number of gastroenterology/hepatology/endoscopy journals nowadays, some of which are "giants" in the field and extremely difficult to compete with. Given the international context, our Editor-in-Chief has successfully managed to achieve and maintain the high standards for our journal.

This was not Professor Acalovschi's last editorial. In fact, I am sure that Monica will continue to be a loyal supporter of JGLD for many years to come by publishing original articles, reviews and editorials, proud to see that this journal continues its progress earning more international respect.

I am very happy that Professor Dan Dumitrascu, who has worked as Associate Editor to JGLD for several years, will now take over as Editor-in-Chief. He is a meritorious successor, and I have no doubt that JGLD will maintain and improve its quality under Dan's leadership. In doing so, our Editor-In-Chief "should give no favors, and should have no friends!" [3].

Carol Stanciu, MD, PhD, FRCP (London)
Institute of Gastroenterology and Hepatology, Grigore T. Popa University of Medicine and Pharmacy, Iasi, Romania

Correspondence: Carol Stanciu; stanciucarol@yahoo.com

Conflicts of interest: None.
DOI: 10.15403/jgld.2014.1121.271.jgd

REFERENCES

1. Acalovschi M. A farewell from the Editor. J Gastrointestin Liver Dis 2017;26:333. doi:10.15403/jgld.2014.1121.264.edt
2. Acalovschi M. An Excellence Award for the Journal of Gastrointestinal and Liver Diseases. J Gastrointestin Liver Dis 2015;24:409. doi:10.15403/jgld.2014.1121.244.exc
3. Kassirer JP. Editorial independence. N Engl J Med 1999;340:1671-1672. doi:10.1056/NEJM199905273402109

Secondary systemic amyloidosis diagnosed by endoscopic ultrasound-guided liver biopsy

To the Editor,

A 65-year-old female presented at our department with fatigue, complaints of right upper quadrant, epigastric pain, nausea, and vomiting. She reported 8 kg weight loss during the past three months and a progressive fatigue. On clinical

examination the patient was jaundiced and afebrile with a pulse rate of 65/min. The abdominal examination revealed shifting dullness and hepatomegaly with the liver 4 cm below the right costal margin. She had normocytic normochromic anemia (hemoglobin 10.7 g/dl), significantly elevated total bilirubin concentration (173 μmol/l), mild increase of aminotransferases with markedly elevated gamma-GT (1,172 U/l) and alkaline phosphatase activities (1,487 U/l). She had also hypoalbuminemia and coagulopathy. Her alcohol consumption was less than 3 drinks per week. HAV IgM antibodies, HBs antigen and HCV antibodies were negative. We excluded acute and chronic liver diseases, including primary biliary cholangitis, autoimmune hepatitis, hemochromatosis, Wilson disease, and alpha1-antitrypsin deficiency.

Hepatomegaly (188 mm) was confirmed by abdominal sonography, and a small focal lesion (20x15 mm) in the pancreatic head was seen at computed tomography (CT). Endosonography (EUS) documented the pancreas within normal limits with a non-dilated main pancreatic duct as well as a hyperechoic liver parenchyma and a small amount of ascites. On further evaluation for infiltrative liver diseases, EUS-guided ascitic fluid aspiration was performed. At the same time EUS-guided liver biopsy (EUS-LB) was performed using a 20G Pro-Core needle to avoid intervening vessels, and this technique enabled us to perform the procedure in the presence of ascites. The biopsy provided adequate histological specimens. The histopathological work-up revealed atrophic, compressed hepatocytes, surrounded by protein mass. These areas were Congo red stain positive, indicating amyloid deposits (Fig. 1). Biopsy of the salivary gland confirmed the diagnosis of amyloid. Bone marrow biopsy revealed plasma cell dyscrasia with amyloid deposits, consistent with multiple myeloma. Subsequently, the patient developed a second-degree heart block, and despite implantation of a permanent pacemaker she passed away.

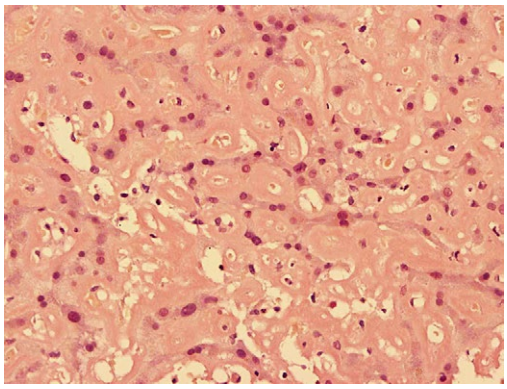

Fig. 1. Positive Congo red stain of the liver specimen consistent with the diagnosis of systemic amyloidosis (x200).

Amyloidosis is a heterogeneous disorder with a wide spectrum of clinical presentations resulting from the extracellular deposition of fibrillar amyloid protein, and may involve any organ in isolation or in conjunction with other organs. Liver involvement in primary (AL) and secondary (AA) forms of systemic amyloidosis is common. However, clinically dominant hepatic amyloidosis is unusual. In amyloidosis with liver involvement, hepatomegaly is reported in 30-90% of patients, and moderate jaundice and cholestasis might also be present [1]. Although our patient had evidence of multiple myeloma, which most likely triggered the secondary amyloidosis, hepatic involvement can occur in both AL and AA amyloidosis [2]. In our case, the cardiac involvement, which is present in 50% of patients with secondary amyloidosis [3], was the limiting factor.

To our knowledge this might be one of the few cases of amyloidosis with hepatic involvement diagnosed by EUS-guided liver biopsy. Due to the fact that the patient had ascites and coagulopathy, she was precluded from percutaneous liver biopsy; hence, we performed EUS-LB. This approach has several advantages: multiple sites can be sampled, the left hepatic lobe is more easily accessed by EUS than by CT or percutaneous ultrasound-guided needle biopsy, and finally the surface area that can be scanned by EUS for an optimal biopsy site is larger. In our case the "real-time" ultrasound guidance helped to avoid intervening vessels and organs in the setting of coagulopathy. Overall, this case highlights that amyloidosis of the liver should be considered in the diagnostic work-up of patients with progressive unclear deterioration of liver function.

Łukasz Krupa[1], Robert Staroń[1], Jacek Pająk[2], Frank Lammert[3], Marcin Krawczyk[3,4], Krzysztof Gutkowski[1]

1) Department of Gastroenterology and Hepatology with Internal Disease Unit of Specialist District Hospital in Rzeszow, Rzeszow, Poland; 2) Department of Histopathology, Silesian Medical University Hospital, Katowice, Poland; 3) Department of Medicine II, Saarland University Medical Center, Homburg, Germany; 4) Laboratory of Metabolic Liver Diseases, Centre for Preclinical Research, Department of General, Transplant and Liver Surgery, Medical University of Warsaw, Warsaw, Poland.

Correspondence: Marcin Krawczyk; marcin.krawczyk@uks.eu

Conflicts of interest: None.
DOI: 10.15403/jgld.2014.1121.271.kru

REFERENCES

1. Bujanda L, Beguiristain A, Alberdi F, et al. Spontaneous rupture of the liver in amyloidosis. Am J Gastroenterol 1997;92:1385-1386.
2. Real de Asúa D, Costa R, Contreras MM, Gutiérrez Á, Filigghedu MT, Armas M. Clinical characteristics of the patients with systemic amyloidosis in 2000–2010. Rev Clin Esp 2013;213:186-193. doi:10.1016/j.rce.2012.09.001
3. Lee MH, Lee SP, Kim YJ, Sohn DW. Incidence, Diagnosis and Prognosis of Cardiac Amyloidosis. Korean Circ J 2013;43:752-760. doi:10.4070/kcj.2013.43.11.752

Radiofrequency ablation of locally advanced pancreatic tumors. The surgical approach

To the Editor,

A 67-year-old female presented in our department, after being diagnosed with advanced pancreatic cancer. Computed

tomography and ultrasound endoscopy showed a tumor (28/15/30 mm) in the uncinated process, with invasion of the superior mesenteric artery (SMA). In the presence of these unresectability criteria, the radiofrequency ablation (RFA) of the tumor by laparotomy approach was decided. In our department, this therapeutic method has been available since December 2017, patients being selected after multidisciplinary meetings (gastroenterologist, oncologist, surgeon, anaesthetist). We standardized preoperative, intraoperative and postoperative management. After the Kocher manoeuver, the intraoperative ultrasound (IOUS) confirmed arterial invasion (Fig. 1A). The histopathological extemporaneous examination evidenced malignant cells. By dissection of the superior mesenteric vein (SMV), the radio-ablation needle was safely introduced by ultrasound guidance, tangential to the venous structure (Fig. 1B). The temperature used for ablation was of 80°C for 10 minutes. The post-ablative necrotic area was assessed by IOUS using an intravenous contrast agent (Sonovue). In the postoperative period, the patient had a portal vein thrombosis with partial reperfusion after heparin treatment, as well as jaundice (inflammatory) solved by endoscopic plastic stent placement. The patient was discharged in the 14th postoperative day. In the 40th postoperative day the conventional US (Fig.1C) and contrast-enhanced CT documented the presence of intratumoral necrosis.

Currently, RFA in combination with systemic oncological treatment seems to offer an improved survival of the patients with unresectable pancreatic tumours, potentially transforming an aggressive neoplastic pathology into a chronic, easier to control disease [1, 2]. The suggested mechanism for the cytoreductive and immunomodulatory effects of this procedure is the release of cytokines, lymphocytes and antibodies [3].

Recent studies have shown RFA applicability through both surgical approach (laparotomy, laparoscopy) and endoscopic ultrasound or percutaneous guidance [1, 4]. The efficacy and the long-term outcome of these patients remain to be evaluated through prospective, multicentric randomized studies [2, 5, 6].

The surgical approach through laparotomy offers some advantages: the confirmation of unresectability (through dissection and IOUS); a good access to difficult tumor locations (isthmus, uncinated process); dissection of vascular structures, which facilitates a safe US-guided approach, with immediate control of possible intraoperative complications (haemorrhage). The control of the ablation zone is performed intraoperatively by contrast-enhanced US. Any necessary palliative procedures (digestive or bilio-digestive bypasses) may be performed at the same time with surgery [5, 7].

RFA of the pancreatic tumors through endoscopic US-guidance and percutaneous approach is possible, offering the benefits of a minimally invasive approach with minimal injury to the digestive tract and abdominal wall. The maximum benefit of these methods can be obtained in patients with a high anaesthetic risk, in whom surgery is contraindicated. The indications for the ideal type of RFA approach are still being evaluated, the multidisciplinary approach being crucial for patients diagnosed with inoperable tumors.

From our point of view, this procedure must be a part of the treatment options of any tertiary centres dedicated to the hepato-bilio-pancreatic pathology, as it might provide a prolonged survival in patients with locally advanced pancreatic cancer.

Adrian Bartos[1], Caius Breazu[2,3], Zeno Spârchez[2,4], Marcel Tantau[2,4], Cornel Iancu[1,2], Dana Bartos[1,5]

1) Department of Surgery, Regional Institute of Gastroenterology and Hepatology; 2) Iuliu Hatieganu University of Medicine and Pharmacy; 3) Department of Anesthesiology and Intensive Care, Regional Institute of Gastroenterology and Hepatology; 4) Department of Gastroenterology, Regional Institute of Gastroenterology and Hepatology; 5) Anatomy and Embryology Department, Iuliu Haţieganu University of Medicine and Pharmacy, Cluj-Napoca, Romania.

Correspondence: Caius Breazu, cbreazu@yahoo.com

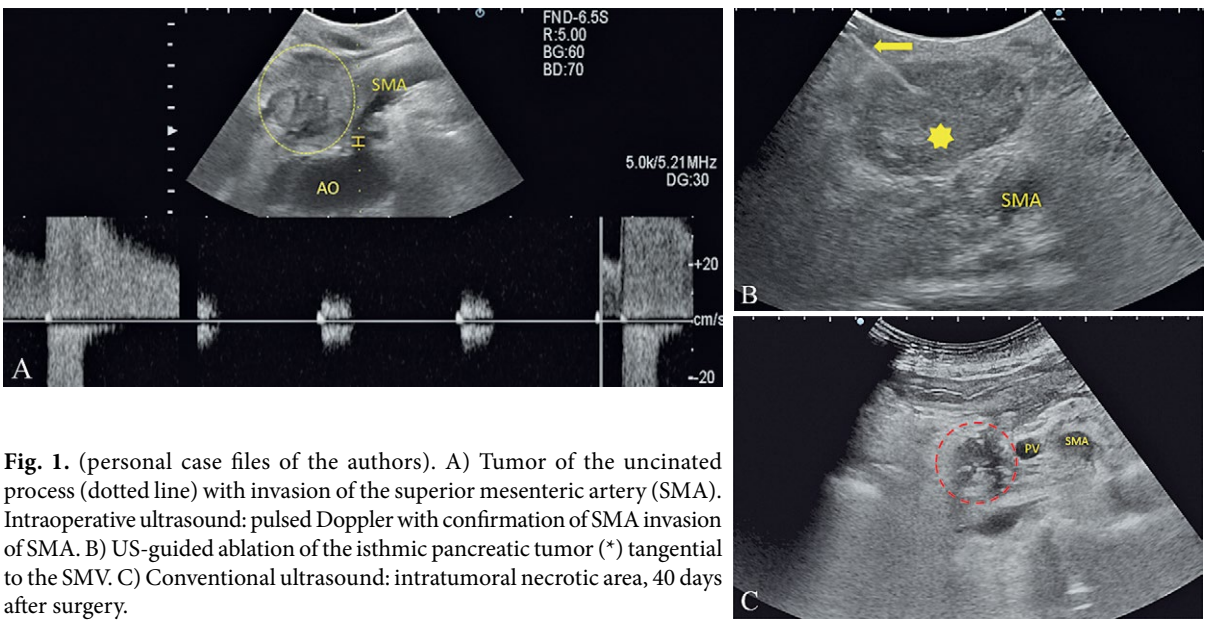

Fig. 1. (personal case files of the authors). A) Tumor of the uncinated process (dotted line) with invasion of the superior mesenteric artery (SMA). Intraoperative ultrasound: pulsed Doppler with confirmation of SMA invasion of SMA. B) US-guided ablation of the isthmic pancreatic tumor (*) tangential to the SMV. C) Conventional ultrasound: intratumoral necrotic area, 40 days after surgery.

Conflicts of interest: None.
DOI: 10.15403/jgld.2014.1121.271.spz

REFERENCES

1. Paiella S, Salvia R, Ramera M, et al. Local Ablative Strategies for Ductal Pancreatic Cancer (Radiofrequency Ablation, Irreversible Electroporation): A Review. Gastroenterol Res Pract 2016;2016:4508376. doi:10.1155/2016/4508376
2. Linecker M, Pfammatter T, Kambakamba P, DeOliveira ML. Ablation Strategies for Locally Advanced Pancreatic Cancer. Dig Surg 2016;33:351-359. doi:10.1159/000445021
3. Ito F, Evans SS. Pre-resectional Radiofrequency Ablation as a Neoadjuvant in situ Tumor Vaccine. J Vaccines Vaccin 2016;7:310. doi:10.4172/2157-7560.1000310
4. D'Onofrio M, Crosara S, De Robertis R, et al. Percutaneous Radiofrequency Ablation of Unresectable Locally Advanced Pancreatic Cancer: Preliminary Results. Technol Cancer Res Treat 2017;16:285-294. doi:10.1177/1533034616649292
5. Rombouts SJ, Vogel JA, van Santvoort HC, et al. Systematic review of innovative ablative therapies for the treatment of locally advanced pancreatic cancer. Br J Surg 2015;102:182-193. doi:10.1002/bjs.9716
6. Girelli R, Frigerio I, Giardino A, et al. Results of 100 pancreatic radiofrequency ablations in the context of a multimodal strategy for stage III ductal adenocarcinoma. Langenbecks Arch Surg 2013;398:63-69. doi:10.1007/s00423-012-1011-z
7. Giardino A, Girelli R, Frigerio I, et al. Triple approach strategy for patients with locally advanced pancreatic carcinoma. HPB (Oxford) 2013;15:623-627. doi:10.1111/hpb.12027

Early detection of advanced pancreatic cancer after DAA-induced virological cure in a liver transplant recipient with hepatitis C recurrence

To the Editor,

Liver transplantation has been considered to have excellent long term survival rate. One of the most common causes of morbidity and mortality in liver transplant recipients is considered to be the occurrence of *de novo* neoplasms, accounting for 30% of deaths in 10 years [1]. In these patients, neoplasms have an aggressive behavior, appear at an earlier age and have a higher mortality [2].

We present the case of a 66 year-old male with a history of orthotopic liver transplantation for HCV liver cirrhosis in 2015, immunosuppression with tacrolimus at stable dose, with HCV recurrence the same year treated with Viekirax®, Exviera® and Ribavirin for 6 months with non-detectable viral replication at the end of treatment. The patient was admitted in our department in June 2016 for diffuse abdominal pain.

At admission, the blood chemistry showed increased pancreatic enzymes and an inflammatory syndrome with normal values of tumor markers. The abdominal CT showed a hypovascular lesion at the head of the pancreas measuring 40 mm in diameter and hypovascular liver lesions (≤ 13 mm).

At this moment the diagnosis of acute pancreatitis was considered in the presence of the pancreatic mass, specific treatment was initiated and endoscopic ultrasound evaluation with fine needle aspiration was performed. It was positive for neoplastic cells. Considering the level of immunosuppression and the increased risk of malignancy in this patient, palliative chemotherapy was initiated.

The patient presented 6 months later with jaundice. Abdominal CT showed progression of the pancreatic lesion with compression and important dilation of the main biliary duct and intrahepatic biliary ducts. Endoscopic retrograde cholangiopancreatography (ERCP) described a modified duodenal papilla and a two-storied stenosis of the choledochus. External biliary drainage was performed under CT guidance, and a rendez-vous procedure was performed for the internalization of the biliary drainage with a multidisciplinary approach (endoscopic and radiologic), which was followed by improvement of the general condition and of the cholestatic syndrome.

Hepatitis C virus (HCV) infection itself has been associated with a significant number of extrahepatic malignancies, and reduction of the systemic immune-inflammatory response through virological cure can be related to a decrease in systemic antineoplastic protection mechanisms [3]. Pancreatic cancer is one of the malignancies that has been related to HCV infection and the premises are the common embryologic characteristics of the liver and pancreas suggesting that HCV could also replicate in pancreatic cells [4]. Given the fact that HCV antigen and replicative forms have been found in many other organs, there is the possibility of HCV implication in extrahepatic cancers [5].

The role of ERCP in treating malignant biliary obstruction has been well defined by many studies. The rendez-vous technique has been described in the treatment of biliary obstruction. It offers an effective nonsurgical treatment option and facilitates stenting of the biliary stenosis when prior attempts have failed [6, 7].

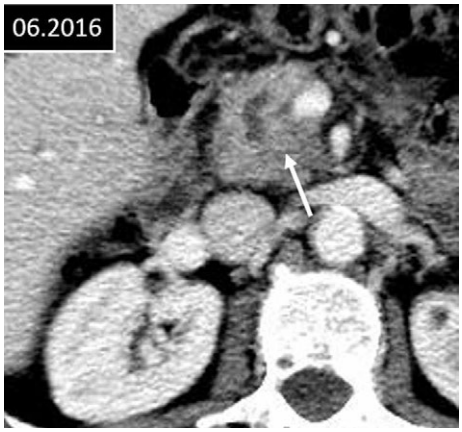

Fig. 1. Contrast enhanced CT: enlargement of the pancreatic head and a hypoenhancing heterogeneous nodule (white arrow) in contact with the superior mesenteric vein which is compressed and superior mesenteric artery; dilated Wirsung duct and choledochus

Fig. 2. Contrast enhanced CT in axial view and coronal reconstruction: increase of the cephalic pancreatic tumour (white arrow) with a heterogeneous pattern (central necrotic area) and small liver metastasis (arrow head).

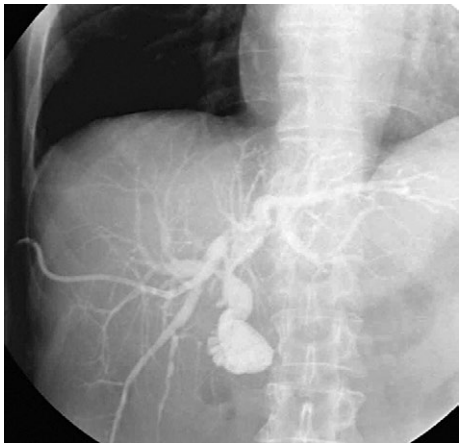

Fig. 3. Endoscopic retrograde cholangio-pancreatography: two-storied stenosis of the choledocus.

In conclusion, liver transplant recipients should be included in intensive malignancy screening programs due to their higher risk, especially if they undergo treatment courses with still an unclear impact on carcinogenesis. Diagnosis can be challenging due to the difficulties in obtaining a clear pathological evidence, but a multidisciplinary approach can clear the pathway towards diagnosis and appropriate treatment.

Carmen Ester[1], Liana Gheorghe[1], Gabriel Becheanu[2], Ioana Lupescu[3], Irinel Popescu[4], Cristian Gheorghe[1]
1) Gastroenterology and Liver Transplant Unit; 2) Pathology Department, Gastroenterology and Liver Transplant Unit; 3) Interventional Radiology Department; 4) General Surgery and Liver Transplant Unit, Fundeni Clinical Institute, Bucharest, Romania

Correspondence: Carmen Ester, carmen.ghidu@gmail.com
Conflicts of interest: None.
DOI: 10.15403/jgld.2014.1121.271.daa

REFERENCES

1. Sanchez W, Talwalkar JA, Gores GJ. Will all liver transplantation patients eventually die from cancer? J Hepatol 2006;44:13–18. doi:10.1016/j.jhep.2005.10.007
2. Verran DJ, Mulhearn MH, Dilworth PJ, et el. Nature and outcomes of the increased incidence of colorectal malignancy fter liver transplantation in Australasia. Med J Aust 2013;199:610–612. doi:10.5694/mja13.10102
3. Fiorino S, Bacchi-Reggiani L, de Biase D, et al. Possible association between hepatitis C virus and malignancies different from hepatocellular carcinoma: A systematic review. World J Gastroenterol 2015;21:12896-12953. doi:10.3748/wjg.v21.i45.12896
4. Zaret KS. Genetic programming of liver and 329- pancreas progenitors: lessons for stem-cell differentiation. Nat Rev Genet 2008;9:329-340. doi:10.1038/nrg2318
5. Li D. Diabetes and pancreatic cancer. Mol Carcinog 2012;51:64-74. doi:10.1002/mc.20771
6. Aytekin C, Boyvat F, Yimaz U, Harman A, Haberal M. Use of the rendezvous technique in the treatment of biliary anastomotic disruption in a liver transplant recipient. LiverTranspl 2006;12:1423–1426. doi:10.1002/lt.20848
7. Miraglia R, Traina M, Maruzzelli L, et al. Usefulness of the „rendezvous" technique in living related right liver donors with postoperative biliary leakage from bile duct anastomosis. Cardiovasc Intervent Radiol 2008;31:999–1002. doi:10.1007/s00270-007-9276-2.