

School going children with persistent jaundice

Q. APART FROM THE WILSON'S, THE EVIDENCE OF HEMOLYSIS EXPECTED IN ANY OTHER CHRONIC LIVER DISEASES LISTED HERE ?

Autoimmune hepatitis/ autoimmune sclerosing cholangitis.

Neonatal idiopathic giant cell hepatitis has been described with hemolytic anemia.

Some amount of low grade DIC causing hemolysis is often seen in end stage liver disease.

Q. How COMMON IS THE KF RING IN HEPATIC FORM OF WILSON COMPARED TO THE "NEURO WILSON"? HOW COMMON IS UNILATERAL KF RING ?

A. KF ring is almost universal in Neurowilson disease but only half the hepatic Wilson disease may have a positive KF ring.

Q. HOW COMMON IS THE ALPHA 1 ANTITRYPSIN DEFICIENCY IN OUR SETTING ? ANY IMPORTANT CLUE(S) FOR THE SUSPECTING IT ?

A. Past studies performed in AIIMS, New Delhi that have looked at the prevalence of A1AT deficiency in liver disease have shown that it is extremely rare/ nonexistent in India. In the Western world, it is a very close mimicker of biliary atresia when it presents very early as neonatal cholestasis.

Q. False positive and false negative ceruloplasmin levels in diagnosing Wilson.

A. Ceruloplasmin level is an acute phase reactant and may temporarily go up in inflammation, spontaneous bacterial peritonitis. Expect it decrease back to low levels during follow up. In the setting of acute liver failure and massive liver necrosis, it is common to see low ceruloplasmin levels irrespective of the etiology of liver disease. Serum ceruloplasmin levels < 10 are more specific for Wilson disease than levels < 20. However it is important to rely on a scoring system like the modified Leipzig score rather than rely on one lab test like ceruloplasmin whilst trying to diagnose Wilson disease.

Q. For an asymptomatic sibling of a Wilson's disease with slightly elevated LFTs, when should we start D penicillamine? Only if there is decompensation?

A. Most children would normalise their LFTs over a period of several months while on oral zinc. D penicillamine is indicated if there is evidence of persisting or progressive liver disease/ progressively accumulation of liver copper despite adequate oral zinc therapy.

Q. IN THE RECENT PAST ENTITY OF ICC , INDIAN CHILDHOOD CIRRHOSIS WAS A WELL KNOWN ENTITY, ANY ATTRIBUTABLE REASONS OF ITS EXTINCTION

A. ICC is thought to have become extinct because of reduced usage of copper utensils. Simultaneously with better understanding, improved interpretation of pediatric liver histopathology, immunohistochemistry and molecular genetics; a number of disorders that

were to be thought to be ICC or ICC like disorders are now diagnosed as metabolic/mitochondrial liver diseases.

Q. Excellent discussion. In wilson disease with DCT negative Hemolysis is Thrombocytopenia due to hypersplenism or due to chronic liver disease/cirrhosis

A. Thrombocytopenia in cirrhosis is usually secondary to hypersplenism

Functional Abdominal Pain

Q. If a fecal calprotectin result is abnormal, but all other investigations are normal, could this still be FAP? Many thanks.

A. Fecal calprotectin is a very sensitive marker for gut inflammation. We would need to rule out IBD before labelling it as FAP.

Q. Dr dhanasekar .excellent. If in your study you did find anxiety disorders high in FAP. Would you not prefer TCA or even SSRI rather than probiotics or B blockers

A. Considering the fact that there are sideeffects associated with SSRI and beta blockers; probiotics, counseling and CBT are to be considered first. Thank you!

Q. In which gender FAP is common?

A. Female > Male

Q. The list of "Red Flag Signs " shown are in Favour of OR against Functional Abdominal Pain ?!

A. Red flags are in favour of an organic cause of pain and go against FAP.

Toddler with chronic diarrhea

Q. What is significance of elevated calprotectin

A. Elevated levels of Fecal calprotectin is a marker of gut inflammation and this often helps differentiate organic causes of abdominal pain like IBD from functional abdominal pain.

Q. Regarding compliance of GFD any test like Hb1Ac in diabetes because TTG Ig A on follow up if pt not regular in GFD but in last 3 months he follows complete GFD then what u expect in TTG result

A. TTG takes a few months to turn negative in celiac disease (3-6 months). Other parameters to check long term compliance would include a good history, nutritional and growth assessment which would falter if you were noncompliant. Most families are usually honest in admitting occasional indulgence in gluten when you ask them nicely.

Q. The specific indication(s) for nitazoxanide in Pediatric age group?

A. Nitazoxanide may be used to treat cryptosporidium and giardiasis

Q. Is it necessary to perform biopsy when we are suspecting toddler's diarrhea?

A. UGI scopy and biopsies are not always required to diagnose toddler's diarrhea. It is however important to look for red flag signs like a mild anemia, a positive tTG or a raised fecal calprotectin that may indicate a more serious and organic cause of diarrhea.