common in Ulcerative Colitis (UC) and is associated with a higher risk of colorectal cancer (CRC). To evaluate the incidence and the outcome of PSC in patients with IBD followed in our Centre.

**Material and methods:** We extracted from our database all patients diagnosed with IBD and cholestasis between January 2006 and October 2012. 22 patients with cholestasis out of 2051 IBD patients were identified and studied with magnetic resonance cholangiopancreatography (MRCP). Patients who did not undergo MRCP were excluded.

**Results:** 12 patients were diagnosed for PSC, (M7/F5), median age 42 years. All patients had a colonic disease, 7 UC (71.4% pancolitis) and 5 Crohn’s Disease. 2 patients were on thiopurine, 3 on antiTNF or comboterapy, 2 on sulfasalazine, 1 on rifaximin, 2 were out of treatment. In all patients the diagnosis of PSC followed that of IBD (median interval time 14.8 years). MRCP showed in 1 patient only the proximal tract of the principal biliary duct (PBD) involved, in 8 patients multiple strictures scattered along the intrahepatic ducts and in 3 patients both intrahepatic and PBD involvement. Ultrasound (US) exam was performed in all the PSC patients, but did not detect any irregularity at the biliary tract. During the follow-up period9 patients were started on sulfasalazine, 1 on rifaximin, 2 were out of treatment. In all patients the diagnostic examination was performed in all the PSC patients, but did not detect any irregularity at the biliary tract. During the follow-up period9 patients were started on UDCA therapy (mean dosage: 1050 mg/day), any patients developed CRC or cholangiocarcinoma (CK), 1 patient developed liver cirrhosis and underwent to liver transplantation.

**Conclusions:** The incidence of PSC in IBD patients was 0.6%, lower than that reported in previous studies. Probably most of the patients with mild cholestasis were underestimated for PSC diagnosis and did not undergo to further examinations relating the altered liver function tests to side effects of the IBD therapy. In fact, when IBD patients with cholestasis performed MRCP, diagnosis of PSC was made in 54% of cases. We recommend a screening for PSC in all IBD patients with cholestasis and colonic involvement to early identify patients that need an intensive follow up to avoid either CK or CRC and in which the use of new anti-fibrotic agents could reduce the progression of the liver disease. In our experience only MRCP but not US was useful for the diagnosis of PSC.

**P.18.10**

**IL28-B POLYMORPHISMS AND NATURAL HISTORY OF PRIMARY BILIARY CIRRHOSIS**

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**Background and aim:** Primary biliary cirrhosis (PBC) is a chronic inflammatory autoimmune liver disease that mainly targets the cholangiocytes of the interlobular bile ducts. Recent evidence showed that rs12979860 CC and rs8099917 TT genotypes of the gene coding for IL28B strongly predict spontaneous clearance of HCV infection and sustained virologic response after antiviral therapy in patients with chronic hepatitis C. Recent study of our centre showed that in the patients with a NAFLD, the IL28B rs12979860 CC genotype, together with PNPLA3 rs738409 GG, is associated with the severity of liver damage. Currently, there are no data regarding a potential association between IL28B polymorphisms and clinical course of PBC. We analysed the impact of IL28B polymorphisms on clinical features and natural history in a prospective cohort of PBC patients.

**Material and methods:** We collected socio-demographic, clinical, biochemical, immunological and histological data at onset, and incidence of disease progression (signs of portal hypertension at ultrasound, oesophageal varices, jaundice, ascites, hepatic encephalopathy) in a prospective cohort of 32 PBC patients. All subjects were treated with ursodeoxycholic acid at a dose of 15–25 mg/kg. IL28B genotyping for IL28B rs12979860 and rs8099917 was carried out using the TaqMan SNP genotyping allelic discrimination method (Applied Biosystems, CA, USA).

**Results:** Mean age at diagnosis was 53.0±12.0 years (range 32–82). All patients were female and AMA positive, and half of them was asymptomatic at disease onset. Histological findings showed an early stage disease (I-II Scheuer) in 24/32 (75.0%). IL28B polymorphisms frequency was distributed as follows: rs12979860 CC 16 (50.0%), CT 10 (31.3%), TT 6 (18.7%); rs8099917 TT 18 (56.3%), GT 12 (37.5%), GG 2 (6.2%). In comparison to non-CC rs12979860 and non-TT rs8099917 groups, patients with CC genotype showed an early histological stage at onset (93.8% vs 62.5%, p=0.03). During follow-up (mean 49 months), seven patients (21.9%) had a disease progression without differences between patients with different IL28B genotypes.

**Conclusions:** In our cohort of PBC patients, rs12979860 CC genotype of IL28B gene presented an higher incidence than in our population HCV infected patients (26.8%). IL 28B CC polymorphism was associated with younger age, 1–2 histological stage at onset and necro-inflammatory activity, similarly as it has been shown to happen for the NAFLD.

**P.18.11**

**FOLLOW UP POST LIVER TRANSPLANTATION: EXPERIENCE OF A NON TRANSPLANTATION GASTROINTESTINAL UNIT**

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**Background and aim:** The Campania Region has the highest incidence of chronic liver disease from HCV, so the demand for liver transplantation is very high. That is why many patients have to be transplanted outside the region or abroad. This cause health and economic problems for both patients and the public health systems to ensure an optimal clinical follow up before, during and after liver transplant. Aim of this study was to evaluate the effectiveness of post liver transplant follow-up performed by a gastroenterology team in the absence of a transplant center in a homogeneous population for anthropometric characteristics from the same geographic area. We also compared the effectiveness of different follow-up regimes recommended by the different transplantation units.

**Material and methods:** From 1993 to 2010, 217 patients consecutively referred for pre or post OLT evaluation to outpatients clinic at Federico II University in Naples (Italy), after written informed consent, were enrolled in the study. Those patients were followed up to a minimum of three months to a maximum of 15 years. Drugs changes, drug-related adverse events, co-morbidity occurred during the follow up and survival were recorded and compared with data from literature.

**Results:** No difference in graft and patients survival, complications, drug-related adverse event was noted in patients followed with different therapeutic approaches (steroid therapy for 3 vs. 6 months, prophylaxis for opportunistic infections). Patients of our series had less frequently dyslipidemia and obesity and psychiatric alterations than that reported in previous studies.

**Conclusions:** Regular assessment of graft function, kidney function and cardiovascular risk factors, as well as regular screening to detect the development of malignancies, can reduce long-term morbidity and mortality after OLT, even when the follow up is performed outside the transplant centre by gastroenterologists experienced in transplant medicine. A stable, trusting patient-physician relationship is crucial to an excellent long-term outcome. However, if this finding is due to better healthcare in a tertiary center close to home and independent from the original transplantation unit, to genetic conditions and/or to environmental factors (Mediterranean diet) it remains speculative.

**P.18.12**

**ANGIOGENESIS FOLLOWING CONVENTIONAL AND DC BEADS-MEDIATED TRANSCATHETER ARTERIAL EMBOLIZATION: ANY DIFFERENCE?**

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**Background and aim:** Transcatheter arterial chemoembolization (TACE) is
the conventional palliative treatment for hepatocellular carcinoma in BCLC intermediate stage. Factors potentially interfering with effectiveness include a hypothetical neo-angiogenic reaction due to ischemia, reflected by a rise in circulating vascular endothelial growth factor (VEGF) levels after TACE. Our study sought any significant difference in neo-angiogenesis before and after conventional TACE (C-TACE), compared to DC-Beads mediated TACE (DEB-TACE), measuring serum VEGF levels.

**Material and methods:** VEGF-A levels (ELISA) were determined in the sera of 88 consecutive HCC intermediate stage patients, before TACE (t0) and after 4 weeks (t1). C-TACE was administered to the first 60 patients and DEB-TACE to the next 28. Tumor vascularization was evaluated at t0 and response to treatment at t1, based on angiography and sCT scan (mRECIST criteria).

**Results:** Complete response was recorded in 25% C-TACE and 29% DEB-TACE patients; mean survival was 32 months (CI 27–36). Objective response rates of both treatments were comparable, the DEB-TACE subgroup showed only a non-significantly better response rate. VEGF t0 levels were higher in multifocal disease (p=0.015) and in patients with no response to TACE (p=0.03). At t1 VEGF levels rose significantly overall (p=0.003), in C-TACE (p=0.04) and DEB-TACE (p=0.02). The rise was more significant in partial responders (p=0.005), especially treated with DEB-TACE (p=0.002); in complete responders the rise was significant only in the DEB-TACE subgroup (p=0.05). The percentage with VEGF rising at t1 was higher in DEB-TACE (p=0.007). Tumor size (p=0.0001), vascularization at t0 (p=0.003, high grades=worse survival) and t0 VEGF levels (p=0.009) correlated with survival. VEGF t0 levels, tumor size and vascularization were indicated in Cox multivariate analysis as independent predictors of survival.

**Conclusions:** DEB-TACE and C-TACE seem equally effective as regards impact on survival rates and response to treatment. DEB-TACE tends to cause higher tissue ischemia, reflected by a more significant rise in t1 VEGF levels, in partial and complete responders, and by a higher percentage of DEB-TACE patients with VEGF rising at t1. High t0 VEGF levels predict worse response to treatment and shorter patient survival. The prognostic value of baseline VEGF, tumor vascularization and tumor burden are equally relevant.

**P.18.13 EARLY WASH-OUT (<60 SECONDS) AT CONTRAST-ENHANCED ULTRASONOGRAPHY (CEUS) IN LIVER NODULES IN CIRRHOSIS IS HIGHLY SUGGESTIVE FOR NON-HEPATOCELLULAR CARCINOMA (HCC) MALIGNANCY**

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**Background and aim:** CEUS was recommended for detection and characterization of liver nodules, with same diagnostic accuracy as contrast CT scan and dynamic magnetic resonance imaging (MRI). However, this procedure has been dropped from the diagnostic algorithm of liver malignancy in the update American Association for the Study of Liver Diseases (AASLD) guidelines 2011, because of false positive HCC diagnosis in patients with cholangiocarcinoma. The present study aimed to assess the role of CEUS in diagnosis of liver non-HCC malignancy.

**Material and methods:** We enrolled 282 cirrhosis patients with liver nodules who underwent ultrasound (US)-guided percutaneous biopsy from 2008 to 2012. We preliminarily performed CEUS in all patients and evaluated wash-out during portal phase of contrast distribution. CEUS-based diagnosis was compared with histological evaluation of specimens obtained through US-guided percutaneous biopsy.

**Results:** Final histological diagnosis was the following: HCC in 230 cases, non-HCC malignancy in 18 cases, regenerative nodules in 25 cases and borderline lesions in 9 cases. Non-HCC malignant lesions included: metastasis in 8 cases, cholangiocarcinoma in 5 cases and non-Hodgkin lymphoma in 5 cases. At CEUS we observed early wash-out (<60 seconds) in all cases of non-HCC malignancy and in only 7 of 230 cases of HCC. Sensitivity, specificity, diagnostic accuracy, positive predictive value and negative predictive value of early wash-out at CEUS for diagnosis of non-HCC malignant lesions in cirrhosis were respectively 100%, 97%, 97%, 72% and 100%.

**Conclusions:** Early wash-out (<60 seconds) of liver nodules in cirrhosis at CEUS has excellent diagnostic accuracy for non-HCC malignancy. We postulate that liver nodules with early wash out (<60 seconds) at CEUS should undergo liver biopsy in order to confirm diagnosis and suggest that CEUS should be reintroduced in diagnostic flow chart of liver malignancy in cirrhosis.

**P.18.14 HEPATIC VEIN ARRIVAL TIME FOR THE DIAGNOSIS OF LIVER CIRRHOSIS: AN EIGHT YEARS SINGLE CENTRE EXPERIENCE WITH CONTRAST-ENHANCED ULTRASOUND**

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**Background and aim:** Vascular derangements and haemodynamic changes in hepatic vascular system are major features of liver disease development. Aim of this study was to determine safety, diagnostic performance and reproducibility of contrast-enhanced ultrasound (CEUS) in evaluating chronic diffuse liver diseases severity.

**Material and methods:** From March 2004 to October 2012, 148 consecutive patients with chronic liver disease (69 patients with liver cirrhosis) were enrolled. We performed 178 valid examinations (86 in cirrhotic patients, 92 in patients suffering of chronic hepatitis). Fourteen patients without any evidence of liver disease were considered as the control group. Contrast-enhanced ultrasound was performed by an intravenously bolus injection of 2.5 ml of Sonovue®. The intensity of enhancement in a main hepatic vein was recorded from 20 seconds before (the basal enhancement trace) to 2 minutes after Sonovue® injection. Using an ultrasound machine built-in contrast software we evaluated the Hepatic Vein Arrival Time (HVAT), the Time To Peak (TTP) and the peak of contrast enhancement.

**Results:** No side effects related to Sonovue® injection were observed. HVAT’s significantly shortened with the worsening of liver disease (controls > non-cirrhotics > cirrhotics): 25.5±4.9 seconds vs. 21.3±3.4 and 14.3±2.5 seconds respectively (p<0.05). Cirrhotic patients also showed a significant shortening of TTP with respect both to patients with chronic hepatitis and to control subjects (39±12.6 vs. 49±12.7 and 52±12.6 seconds respectively, p<0.05). The peak of enhancement didn’t differ among study groups. Receiver Operating Curve (ROC) analysis demonstrated HVAT to have the best accuracy in excluding liver cirrhosis (Area Under the ROC [AUROC]: 0.982). HVAT <17 seconds showed 98.8% sensitivity and 93.4% specificity to exclude liver cirrhosis. In cirrhotic patients HVAT is inversely related to MELD (Spearman’s coefficient –0.31, p=0.004). CEUS revealed a high reproducibility: inter- and intraobserver kappa coefficients for calculation of HVATs were respectively 0.90 and 0.96.

**Conclusions:** CEUS can be an alternative method for a non-invasive staging of liver diseases. Earlier HVATs and TTPs can be reliably used to exclude liver cirrhosis in a clinical setting.

**P.18.15 CONTRAST-ENHANCED ULTRASOUND EVALUATION OF TUMOR RESPONSE TO ANTI ANGIGENETIC TREATMENT IN PATIENTS WITH ADVANCED HEPATOCELLULAR CARCINOMA**


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**Background and aim:** Sorafenib has become the standard first-line treatment for patients with advanced hepatocellular carcinoma (HCC). Contrast enhanced ultrasound (CEUS) is now recognized as a functional imaging tech-
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