THIRD ANNUAL GENERAL SCIENTIFIC MEETING OF GASLIDD
Gastro Foundation : Best of EASL

The Ghana Association for the Study of Liver and Digestive Diseases (GASLIDD) held their Third Annual General Scientific Meeting at the Elmina Beach Resort, Cape Coast, Ghana from 1-2 September 2017. Chris Kassianides, Chairman of the Gastro Foundation of South Africa together with Dr Richard Anthony, chairperson of the Local Organizing Committee of the Cape Coast Chapter of GASLIDD and supported by EASL (Professors Frank Tacke and Marco Marzioni) put together an excellent 2 day meeting with the theme of "The Burden of Liver and Gastrointestinal malignancies in Ghana: The role of the GI Practitioner".

Our visit to Cape Coast began with an emotionally moving visit to the Cape Coast Castle, one of about forty "slave castles" built on the Gold Coast of West Africa originally by the European traders for trade in timber and gold, but later used in the trans-Atlantic slave trade. These castles were used to hold slaves before they were loaded onto ships and sold in the Americas, especially the Caribbean. This "gate of no return" was the last stop before crossing the Atlantic Ocean.

President Barack Obama visiting the slave castle

The first session of the meeting covered malignancy. Professor Wendy Spearman discussed the epidemiology and risk factors associated with Hepatocellular carcinoma in sub-Saharan Africa (SSA), stressing the need for better registries particularly from Southern Africa to accurately assess the burden of disease and impact of preventative and therapeutic regimens. In the WHO Africa Region according in 2012, there were 39 000 new cases, 37 000 deaths and a 5-yr prevalence of 26% (GLOBOCAN 2012). HCC is an aggressive tumour with an incidence matching mortality rate. The

median age of presentation in rural born men in SSA is 34,7 years and HCC is usually multifocal and inoperable. Hepatitis B, Hepatitis C and Aflatoxin B1 are major risk factors for the development of HCC in Africa, but Non-alcoholic fatty liver disease (NAFLD) is increasingly recognized as an important risk factor.

The Africa Liver Cancer Consortium which does not include any southern African countries showed that factors independently associated with poor survival included hepatic encephalopathy, tumour diameter, α-fetoprotein level, performance status and lack of treatment. Active implementation of preventative measures is essential. Surveillance programs and early diagnosis with appropriate imaging and access to therapeutic regimens is needed to improve the prognosis of HCC.

Dr Sarkodie gave a talk on the role of Interventional radiology and GI malignancies in Ghana and stressed the need to increase training capacity and access to the locally ablative therapies such as TACE and microwave ablation for the management of hepatocellular carcinoma. This was followed by a talk from Dr Tachi on GERD and cancer association.

The afternoon session covered the management of cirrhosis, non-invasive assessment of fibrosis and the role of the liver biopsy. Prof Mark Sonderup gave an excellent overview on how to improve the clinical outcomes of cirrhotics: covering the pathophysiology of bacterial translocation and bacteremias in cirrhosis and the need to recognize and treat infections early with appropriate antibiotics as infection can precipitate acute-on-chronic liver failure; the role of intravenous 20% albumin in reducing the risk of hepatorenal syndrome in spontaneous bacterial peritonitis; increased risk of spontaneous bacterial peritonitis with PPIs; antibiotic prophylaxis on admission with a variceal bleed improves prognosis; mounting evidence of survival benefit in patients on beta-blockers even in advanced cirrhosis with refractory ascites; large volume paracentesis (>5-6L) without albumin leads to circulatory dysfunction and renal impairment; and treatment of the underlying cause of cirrhosis eg Tenofovir in Hepatitis B and DAA therapy for Hepatitis C improves outcomes even in decompensated cirrhotics.

Professor Segun Ojo looked at the role of the liver biopsy in assessing necro-inflammation and fibrosis in viral hepatitis and particularly the importance in establishing the role of competing aetiologies: viral hepatitis, drug-induced liver injuries, iron overload, NAFLD and alcoholic liver disease. However, the access to liver biopsies and trained histopathologists in sub-Saharan Africa is limited and increasingly non-invasive tests are being used to assess fibrosis. Prof Sonderup discussed the benefits of non-invasive blood tests such as the APRI and Fib-4 Scores and vibration controlled transient elastography (Fibroscan) as potential point-of-care testing for fibrosis staging, enabling rapid assessment and linkage to care for individuals with viral hepatitis: initiation of tenofovir for Hepatitis B and deciding on duration of DAA therapy or potential need for ribavirin for Hepatitis C.

The last session on the day covered liver transplantation. Ghana is about to embark on a Liver transplantation program and Dr Offei gave an overview of the training of their transplant surgeons and the planning that has taken place to make liver transplantation an attainable therapy for patients with end-stage liver disease. To date, Ghanaians with end-stage liver disease who can afford liver transplantation must travel abroad for a living related liver transplant. Professor Spearman gave an overview of the challenges faced in developing transplant programs in developing countries.

Careful planning with the development of medical, surgical, anaesthetic and ICU protocols; and training of staff is essential. This requires dedicated funding for transplant programs and importantly both local hospital and Government support is essential for sustainability of programs. A team approach is necessary with ongoing mentoring of staff. It is imperative to ensure secure access to lifelong medical care and subsidized immunosuppression.

The Saturday morning session started with a talk on the practical approach to a patient with liver disease by Dr Tachi. The metabolic syndrome with its comorbidities of obesity, diabetes mellitus, hypertension and NAFLD is increasing in prevalence in SSA. Dr Adjei discussed the standard evaluation of NAFLD and Prof Frank Tacke covered the new developments in pathogenesis and therapeutics.

This was followed by a session on Viral Hepatitis. Professor Wendy Spearman gave an overview of HIV-HBV coinfection. 1.96 M individuals are co-infected in SSA and HIV-HBV coinfections tend to outnumber HIV-HCV co-infections in SSA. HIV promotes HBV mother-to-child transmission and a more aggressive natural history of chronic hepatitis B. Liver-related mortality is 2-fold higher in HBV-HIV than HCV-HIV co-infections and ART improves overall survival even in cirrhotics. Prof Frank Tacke covered the recent EASL guidelines on Hepatitis C management including the recent EASL smartphone application for easy access to up-to-date DAA regimens. Prof Sonderup addressed DAA options in SSA; stressing the need for simplified guidelines, point-of-care diagnostic testing and fibrosis assessment and the role of pangenotypic regimens that simplify therapy in regions which are HCV pangenotypic.

Professor Marco Marzioni gave excellent talks on the practical approach to a patient with jaundice and complications of cirrhosis. His talk on HCC screening, diagnosis and therapy was very pertinent to SSA where patients with HBV-associated HCC tend to present late with multi-focal and inoperable malignancies. Alpha-fetoprotein remains relevant as a screening modality in SSA, and it is imperative to improve access to ultrasound in SSA to detect small operable lesions. The systemic therapeutic options for HCC are rapidly expanding and show promising results: Regorafenib, a multikinase inhibitor in phase 2 clinical trials and Nivolumab, a Programmed Death-1 (PD-1) Inhibitor (CheckMate 040 Study); but there have been no trials validating their use in SSA.

Professor Tacke also gave a talk on acute-on-chronic liver failure, a syndrome characterised by acute decompensation of chronic liver disease associated with multi-organ failure and high short-term mortality. Alcohol and chronic viral hepatitis are the most common underlying liver diseases. Up to 40%–50% of the cases of ACLF have no identifiable trigger; in the remaining patients, sepsis, active alcoholism and relapse of chronic viral hepatitis are the most common reported precipitating factors. An excessive systemic inflammatory response seems to play a crucial role in the development of ACLF.

Overall it was a very successful meeting. Our thanks to GASLIDD for inviting us to participate in this meeting and for their wonderful hospitality. We are also grateful to EASL for their ongoing support in bringing the Best of EASL to Africa. Our visit ended on an exciting note with a police escort back to Accra.

Wendy Spearman