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Threat of Dengue Fever and Dengue Haemorrhagic Fever to Egypt from Travelers

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ABSTRACT

Dengue (DF) and dengue hemorrhagic fever**s (**DHF**)** are present in urban and suburban areas in the Americas, South-East Asia, the Eastern Mediterranean and the Western Pacific, but dengue fever is present mainly in the rural areas of Africa. Several factors have combined to produce epidemiological conditions in developing countries in the tropics and subtropics that favor viral transmission by the main mosquito vector, *Aedes aegypti* as the rapid population growth, rural-urban migration, inadequate basic urban infrastructure (e.g. the unreliable water supply leading householders to store water in containers close to homes) and the increase in volume of solid waste, such as discarded plastic containers and other abandoned items which provide larval habitats in urban areas. Geographical expansion of the mosquito has been aided by the international commercial trade particularly in used car-tires which easily accumulate rainwater. Increased air travel and the breakdown of vector control measures have also contributed greatly to the global burden of DF and DH fevers. The presence of *Aedes aegypti* and endemic DF and DHF in the neighboring regional countries must be born in mind of the Public Health Authorities.

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Intrafamilial Transmission of HCV

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ABSTRACT
Egypt has high prevalence rate of HCV (10.8%) with many routs of transmission . However in 40-45% of patients the route of transmission is not definite (community acquired).There are three routs of intrafamilial transmission of HCV :1-Houshold relatives due to reused scissors and needles with 4.7% chance of transmission per year ,2-Sexual with increase prevalence for more than 15 years of marriage and 1/2 – 2% chance of transmission per year and 3-Vertical with 5 % chance of transmission per year.

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Arthropod Vectors in Toshka ,Egypt

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ABSTRACT
Toshka is a newly developed area in the south of Egypt near Sudan .Many tropical diseases could be transmitted from Sudan . We spotlight on the arthropods found in Toshka which may transmit diseases from Sudan to Egypt.*Simulium* (vector of oncocerciasis) ,*Chrysops* (vector of Loaiasis) ,*Culicoides* (vector of filariasis and horse sickness), *Anopheles sergenti* (vector of malaria), *Aedes aegypti*(vector of Dengue) ,*Tabanus taeniola* (vector of anthrax),*Phlebotomus papatasi*(vector of cutaneous leishmaniasis) and *Phlebotomus langeroni*(vector of visceral leishmaniasis) all are found in Toshka.

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Recent Guidelines for Treatment of HCV

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ABSTRACT
The prevalence of HCV in Egypt is 9% with 70000-140000 new infections each year and the mortality from liver diseases is 40000 deaths per year. The goal of treatment of chronic HCV is sustained virological response (SVR) which means PCR negative 6 months after the end of combined treatment by interferon and ribavirin . Patients with negative PCR at 4 , 12 ,24 , 48 weeks of therapy and SVR have 98% cure rate from the virus. Pre-treatment assessment includes: HCV RNA by PCR, liver biopsy elastography or Actitest and Fibrotest (when validated to substitute liver biopsy) , genotype assessment, abdominal ultrasonography, alpha fetoprotein , history of alcohol intake and detection of auto-antibodies.

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HCV Update

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ABSTRACT
HCV is a major public health problem in Egypt . HCV is responsible for 20% of acute hepatitis , 70 % of chronic liver diseases ,60 % of HCC and 30% of liver transplantation. The predictors of response to combined treatment by interferon and ribavirin are: 1- genotype; 2 and 3 have better response ,2-age; younger patients have better response , 3-liver injury ; minimal liver damage seen histologically has good response ,4-sex ; females are more responders , 5-body mass index ; thin patients are good responders , 6- viral load; HCV RNA less than 2 000000 iu/ml has better response,7- smokers have bad response , 8-low level of GGT has good response , 9- alcoholics have bad response ,10- co-infections with HIV and HBV have bad response, 11- Interleukin 28B polymorphism predicts response to interferon ,12-patients with insulin resistant have poor response and 13- blacks with genotype 1 have poor response. HCV causes both hypo and hyper thyroidism and 7.3-15 % of patients treated by interferon have thyroid dysfunction.

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Clostridium Difficile Colitis

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ABSTRACT
Clostridium difficile is a gram positive anaerobic spore forming bacteria. It secretes 2 potent exotoxins ; enterotoxin A and cytotoxin B .It is called antibiotic associated diarrhea. The risk factors for *C. difficile* infection are antibiotic intake in the last 2 months , old age and hospitalization. Antibiotics as cephalosporins, penicillin, clindamycin , macrolides lead to disturbance of gut flora and colonization by *C. difficile*. The clinical spectrum ranges from asymptomatic , self limited diarrhea up to fulminant bloody diarrhea with perforation of the colon . Laboratory investigations revealed leucocytosis ,

RBCS in stool and positive *C. difficile* toxin by ELISA in stool .Yellow pseudo- membrane of the mucosa of the colon could be seen by endoscopy .The disease has 25% mortality rate in elderly patients. Treatment is by discontinuation of antibiotics, administration of metronidazol orally or by intravenous route and oral only vancomycine. Nitazoxanide , probiotics and cholestyramine could be used.

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Spontaneous Bacterial Peritonitis in Cirrhotic Patients

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ABSTRACT

Cirrhotic patients with poor liver functions are prone to bacterial infections as spontaneous bacterial peritonitis (SBP) , urinary tract infections , bacteraemia and respiratory tract infections. SBP should be suspected in any deterioration of the cirrhotic patients . 10- 27 % of admitted ascetic patients have SBP. The recurrence rate and mortality of SBP are 70% and 31% respectively. One third of cases of hepato-renal syndrome have SBP. Clinically the patient of SBP has fever , abdominal pain , tender abdomen , encephalopathy and hypotension. The long term daily prophylaxis by oral norfloxacin carries the risk of resistance to quinolones and should be restricted to high risk patients. The diagnosis is established clinically, by findings of > 250 polymorphoneuclear leucocytes (PMN) / dl in ascetic fluid and ascetic fluid culture. Treatment should be started before the result of the culture. Secondary bacterial peritonitis should be suspected if there is a lack of response to antibiotics , 2 or more organisms detected in ascetic fluid culture , ascetic fluid glucose < 50 mg/dl , ascetic fluid protien > 10 gm / dl and ascetic fluid LDH .> serum LDH. Bacterascites means culture positive ascetic fluid with PMN < 250 /dl in the ascetic fluid. Treatment of SBP is by empiric cefotaxime 2 gm /12 hrs for 5 days . Ceftriaxon , amoxicillin- clavulinic acid and quinolones (if no prophylaxis with norfloxacin) could be used.

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Sedation for Endoscopy

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ABSTRACT

Ideal sedation has the following characters : easy administration ,large safety profile , rapid onset , induces amnesia , air way safer and keeps the patient cooperative . Side effects of sedation are : agitation , deep sleep , loss of protective air way reflexes , hypoxia and hypotension. The patient should be monitord during sedation by pulse oximetry , ECG or capnography .Supplemental O2 may be needed during sedation. Midazolam is commonly used during endoscopy in a dose of 1-2 mg I.V. up to 5mg , it has minimal side effects in the form of respiratory and cardiovascular instability .The antidote of midazolam is flumazenil. Propofol could be used due to its rapid onset and offset .Propofol depresses the respiratory center so, facilities for endotracheal intubation should be available during its use.

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Anti Fibrotic Treatment: the Present Status and Future

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ABSTRACT

There is an increasing evidence that fibrosis is a dynamic and reversible process .Clarification of the mechanism of fibro-genesis with particular action of stellate cell biology, has generated a great hope that novel therapies will evolve. Until now, however, no drug has been approved as an anti -fibrotic. In reality, there may already be many existing drugs with well-established safety profiles, whose mechanism of action will be also anti- fibrotic even though they have been developed for other indications. There are several points of attack in developing antifibrotic agents :1- Eliminate the cause(s) of injury and their mediators , reduce inflammation and the immune response. , 2-Target specific signaling: receptor ligand interaction, intracellular signaling .,3- Reduce fibro genesis by inhibiting matrix synthesis and 4-Resolve fibrosis by: increasing scar matrix degradation; stimulating apoptosis of stellate cells;and BM or cell transplantation. Emergence of effective drugs that ameliorate fibrosis approaching, and will transform the outlook for patients with chronic liver disease. To date with the available drugs, we can say that liver fibrosis is regressive but not completely reversible disease.

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Fibroscan as a Tool in Diagnosis of Liver Fibrosis and Cirrhosis

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ABSTRACT

The gold standard for diagnosis of liver fibrosis is liver biopsy , but it is an invasive technique needing relatively large size of liver tissue. An alternative to liver biopsy is the non-invasive elastography which depends on measuring the speed (velocity) of propagation of shear waves (vibration) through the liver tissues and it depends on the density of tissues. Fibroscan is a non – invasive , painless , outpatient , operator independent procedure .It has limitations as in obese patients with thick chest wall (use XL probe), in children with thin chest wall (use S probe)and in patients with narrow intercostal spaces. The normal elastography is 5.5±1.6 kilopascals (kpa). Fibroscan is useful in chronic HCV , HBV ,alcoholic liver diseases , NASH, NAFLD and cirrhosis. Elastography according to meta-analysis study of 17 kpa is associated with cirrhosis , 49 kpa with ascites , 54 kpa with HCC and 63 kpa with bleeding varices