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PRIMARY SCLEROSING CHOLANGITIS IN TROPICAL AFRICA: NIGERIAN AND TANZANIAN EXPERIENCE

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Primary sclerosing cholangitis (PSC) is a chronic fibrosing inflammatory process that results in the obliteration of the biliary tree and biliary cirrhosis. There is variability in the extent of involvement of the biliary system. The majority of patients with primary sclerosing cholangitis have underlying inflammatory bowel disease, namely ulcerative colitis or Crohn's disease. Patients with primary sclerosing cholangitis are more likely to have ulcerative colitis than Crohn's disease (85% versus 15%), with approximately 2.5–7.5% of all ulcerative colitis patients having primary sclerosing cholangitis. The strictures are located in both the intrahepatic and extrahepatic ducts in more than 80% of the patients.

PSC eventually leads to bile stasis, progressive hepatic fibrosis, and ultimately to cirrhosis, and the need for liver transplantation. In addition, patients with PSC are at risk for the development of cholangiocarcinoma and other extrahepatic malignancies.

Since the first description of Primary Sclerosing Cholangitis over a century ago by Hoffman in 1867, the disease has remained an uncommonly diagnosed syndrome of unknown cause, characterized by chronic fibrosing inflammation of bile ducts, usually affecting both the extrahepatic and intrahepatic biliary ductal systems.The natural history of PSC is characterized by slow and relentless progression from an asymptomatic stage to a condition characterized by symptoms of cholestasis and complicated by cirrhosis, portal hypertension, liver failure and possibly carcinoma of the bile ducts. Although this progression may take over a decade or longer, the time course is unpredictable. Early non-invasive and pre-icteric Identification of this condition requires magnetic resonance or endoscopic cholangiopancreatography (MRCP or ERCP).

PSC is an unusual cause of chronic liver disease worldwide. It is even less common in many parts of Africa where viral hepatitis B and C are endemic and ulcerative colitis uncommon. In Western populations, PSC is thought to occur predominantly in men, with an average age of 40 years at diagnosis and with auto antibodies occurring in up to 53% of these subjects. In contrast, various studies done in Western countries suggest that among patients of African descent, females appear more susceptible than males and have less

concurrent inflammatory bowel disease. There is no epidemiological data or case series on PSC from Tropical Africa.

Jones et al, (1979) reported the case of a 39-year old Tanzanian man who presented with cholestatic jaundice and required diagnostic laparotomy, intraoperative cholangiograpy and liver biopsy for establishing the diagnosis of PSC.

In developed Western countries, diagnosis of PSC is currently made using ERCP. The advent of MRCP as a screening tool for suspected patients has made non-invasive, early and pre-icteric diagnosis possible. In these subjects, localized areas of dilatation proximal to multifocal biliary strictures produces a characteristic beaded appearance on cholangiography.

Although there is a lack of statistical data about the incidence and prevalence of PSC in Nigeria, Owoseni O.O. et al described a case of a 47-year old woman who presented with a 6 month history of right upper quadrant pain, associated with intermittent jaundice, and generalized pruritus and weight loss. She also complained of intermittent loose stools 4 to 6 times daily, associated with mucus.After extensive investigations, and based on the clinical presentation, the diagnosis was confirmed to be PSC, The patient was started on symptomatic management for pruritus initially with cholestyramine, but this was later changed to ursodeoxycholic acid and antihistamines with good clinical and biochemical response.

A diagnosis of PSC is based on a constellation of clinical, biochemical, and typical cholangiographic features, and usually without the need for liver histopathology. Further understanding into PSC pathogenesis is desperately required in order to effectively improve our current approaches to the management of this disease.

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CHRONIC CHOLECYSTITIS AND GOUT - AN UNFAVORABLE TANDEM WITH DANGEROUS CONSEQUENCES

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The study features of any disease in the conditions of polimorbidity is important from the standpoint of increased risk of mortality, disability and significant deterioration in quality of life. In conditions of comorbidity and polimorbidity largest attention is deserved comorbid diseases which have common pathogenetic links with the main disease or other mechanisms that increase the risk of complications. Complicated impact of comorbid diseases