mation, oxidative stress and bile salt-related tubular damage may contribute significantly to its development. That is, HRS has an additional structural component that would not only make traditional diagnostic criteria less reliable, but would explain the lack of response to pharmacological treatment with vasoconstrictors plus albumin that correlates with a progressive increase in inflammation.

Management: Medical — The patient admitted on 4/3/22 in regional hospital was prescribed medication Tab Lasix 40 mg, Tab Metoclopramide 40 mg, Tab Thiamine, Inj Vit K 10 mg OD, Tab Neurobim pan-OD. Further culture test was done of ascites fluid which revealed presence of bacteria confirming Spontaneous Bacterial Peritonitis. Inj Pantoprazole 500 mg BD, Inj Albumin 20 % BD, Inj optineurin 1 ampule OD, Inj Cefotaxime 2 gm TDS, Inj Dopamine 3 mcg/kg/min, Inj Octreotide 10 mg IM.

Surgical: Liver transplant is awaited. And a follow-up diagnostic paracentesis was done after 48 hours of initiation of treatment for testing the efficacy of treatment. TIPS (Transjugular Intrahepatic Portosystemic Shunt) procedure was consulted with the surgeon.

Follow up: Advice the patient to visit the hospital after one week. He's prescribed to take Tab Lasix 40 mg, Tab Metoclopramide 40 mg, Tab thiamine and Tab Neurobin pan OD.

Also, the following advice was given:
1. Prevent the infections.
2. Maintain personal hygiene.
3. Proper rest and sleep.
4. Intake of healthy diet.
5. Regular follow up until proper donor is found.

Conclusion

In most cases, clinically seen case is of HRS type I which has a bad prognosis, having a median survival rate of 4-6 weeks without transplant. Also, medicines like Terlipressin or Norepinephrine or Midodrine+ SC Octreotide can be used in patients awaiting liver transplant.

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ASPECTS OF CROHNS DISEASE BASED ON AGE
AND DIAGNOSIS ON ITS LOCATION AND CLINCAL TYPES

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Introduction

Crohn's disease (CD) is a type of inflammatory bowel disease, it causes inflammation of your digestive tract, which can lead to abdominal pain, severe diarrhea, weight loss and malnutrition, inflammation caused by CD can involve different areas of digestive tract and it also affects different layers of bowel in different people [1]. CD is increasing in prevalence worldwide. It arises from a complex interplay between both genetic predisposition and environmental influence. The impact of CD

based on age is carried out by the Montreal classification divides CD into three categories according to age at diagnosis: A1 (< 17 years), A2 (17–40 years), and A3 (> 40 years) [2]. CD works on the pathogenesis on chronic inflammation from T-cell activation, after activation by antigen presentation, unrestrained response of type-1 T-helper cells predominate in CD as a consequence of defective regulation. The disease severity and prognosis differ among these groups, however, only a few studies have provided insights into the importance of epidemiological and phenotypical differences in elderly patients. Even less attention has been paid to group A3 as a whole, although elderly patients with CD account for 17–35 % of the total cases. A search of databases and clinical practice guidelines was performed to provide the most up-to-date evidence-based approach for diagnosing and managing patients with CD [3]. No single gold standard investigation exists. Whilst full ileocolonoscopic with biopsies remains the mainstay for diagnosis, other less invasive imaging modalities are being actively considered in the workup, as well as the use of serological markers [4]. Management should incorporate dietary and lifestyle modifications where necessary, the use of medications in induction and remission of disease, and consideration of surgical intervention where medical therapy has failed.

Aim

This article aims on evaluation of the CD based on age, clinical trials, diagnosis based on prospective study and carrying out an appropriate management in the involved patients.

Material and Methods

This article carries out around 25 patients among them males 11 and females 14 and their age was characterised according to the Montreal classification. Age at diagnosis was categorised as <17, 17–40, 41–59 and ≥60 years. Logistic regression analysis was performed to examine the association between advanced age ≥60 and complicated disease Patients with either stricturing or penetrating disease were classified as having complicated disease. Therefore, The Data was carried out as means, medians and standard deviation and analysed statistically by Analysis of Variance ANOVA.

Results and Discussion

The prospective study of CD was evaluated from Andhra University from 2021. We compared differences in Crohn's Disease among 25 patients in those 8 patients <17 years, 4 patients 17–40 years, 6 patients 41–59 years and 7 patients ≥60 years of age. We defined 'elderly' as those patients diagnosed at age ≥60 years. Disease behaviour was divided into the following categories: inflammatory, stricturing or penetrating according to the 2005 Montreal Classification system, patients with stricturing or penetrating disease were classified as complicated behaviour and others are non-complicated. Among the enrolled patients 8 (39 %) had complicated disease. As age of diagnosis increased, the proportion of patients with complicated disease behaviour decreased and 20% of patients who were <17, 17–40, 41–59 and 60 years of age and older had complicated disease, respectively ($P < 0,06$). When compared with persons <60 years, those ≥60 years had a significantly decreased odds of complicated disease. The proportion of patients with colonic disease increased from 39 % in patients <17 compared with 35 % in patients ≥60 years ($P < 0,98$) and while comparing differences between patients at 41–59 years and those ≥60 years adjusting for disease location, family history of IBD, smoking and disease duration we found that there was no association between diagnosis at ≥60 years and complicated behaviour compared with those diagnosed between 41 and 59 years.

35 % of the patients were diagnosed at ≥60 years shown increasing age at diagnosis and was associated with isolated colonic disease and non-complicated disease behaviour. Patients diagnosed at an older age had decreased duration of disease. After adjustment for confounding variables, the association with complicated dis-

ease behaviour was no longer significant. Our study found that 35% of patients diagnosed with CD ≥60 had isolated colonic disease.

It is possible that older patients are diagnosed when asymptomatic or minimally symptomatic during colorectal cancer screening. If this were true, we would expect older patients would have a decreased time between symptom onset and diagnosis. We compared the amount of time elapsed between symptom onset and time of diagnosis by age group. We found that time from symptom onset to diagnosis increased with increasing age. Therefore, it is unlikely that older patients are diagnosed at a preclinical stage with colonic disease location as a consequence of screening for colorectal cancer and among older patients, 4 patients with diverticula were more likely to have granulomas (16 vs 13 % of patients without diverticula, P < 0,84), but the diagnosis of CD was confirmed by lesions remote from the diverticula in most cases. It is also possible that elderly patients are less likely to undergo small bowel imaging and/or video capsule endoscopy for staging which would limit the detection of small bowel involvement. Our study is limited by the small number of patients diagnosed at ≥60 years. Since disease duration decreased significantly with age at diagnosis, it is possible that over time older patients will develop more complicated behaviour. Therefore, beside Early resection rates were not higher in older patients, who were less likely to require immunosuppressants or re-admission for CD flares, as compared to younger patients and the rest subjected patients carried out lifestyle modifications and diet therapy. Five-year mortality in older patients was 16 % but was unrelated to CD.

Conclusion

Our study suggests that patients diagnosed with CD ≥60 are more likely to exhibit isolated colonic disease location and less likely to have complicated disease, although the latter was not significant by carrying out appropriate diagnosis and treatment. The age specific incidence, clinical features, and prognosis of CD were little higher among the elderly are comparable to those in younger individuals. Colon involvement is more common. Concomitant diverticular disease is common and should prompt a search for CD lesions at other sites to confirm the diagnosis. Older patients are less likely to require immunosuppressants or admission for flares. As per data we associated Five-year year mortality in older patients was 16% but was unrelated to CD.

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UPPER GASTROINTESTINAL CROHN'S DISEASE

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Introduction

Upper gastrointestinal Crohn's is an under-reported, under-recognized phenotype of Crohn's disease (CD). Compared to patients with an ileocolonic localization, patients with Crohn's disease in the upper gastrointestinal tract more frequently