

quantitative variables, and frequencies (percentages) were used for qualitative variables.

Results: A sample of one hundred and twenty-two patients (56.5% were men and 43.4% were women) was analyzed, of which 87 (71.3%) corresponded with a diagnosis of UC and 35 (28.7%) with a diagnosis of CD. Hepatobiliary manifestations were found in 27 patients (22%), with steatosis (9%) and PSC (5.6%) being the most frequent. Only in one patient, two simultaneous manifestations were found (HAI and PSC). Thirty-eight patients presented alterations in hepatic biochemical tests, of which 29% did not correspond to any known hepatic complication at that time. (Figure 1).

Discussion: Although the best-described manifestation in IBD is PSC, in our study, they stand out because a considerable percentage of patients present alterations in hepatic biochemical tests or in imaging studies, which are not related to a known hepatobiliary pathology and which may be of multifactorial etiology.

Conclusions: The prevalence of hepatobiliary alterations in IBD is considerable, which is why clinical, biochemical and imaging studies monitoring are required periodically to perform the appropriate diagnostic and therapeutic procedures in a timely manner.

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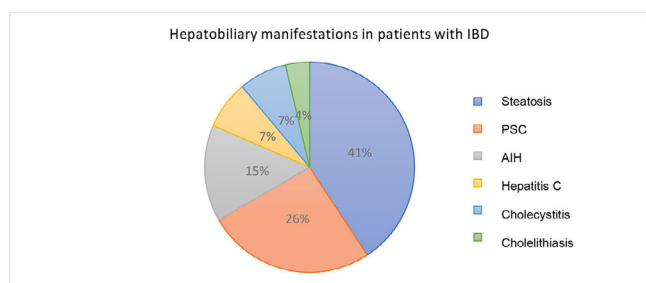


Figure 1.

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Left-sided portal hypertension as a complication of chronic pancreatitis in a young patient. A case report

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Introduction and Objectives: Left-sided portal hypertension occurs due to obstruction, stenosis, or thrombosis of the splenic vein. The most common causes are pancreatic, including chronic pancreatitis (31.8%-53.8%), pancreatic pseudocyst, and neoplasms.

Clinical Case: A 22-year-old man with an 11-year history of trans-flective pain episodes every three months, without any other

symptoms. In the last six months, increased frequency and intensity. He was admitted to the emergency room for mild acute pancreatitis, amylase 181u/l, lipase 230u/l, CRP 35.7mg/L, Procalcitonin 0.04ng/ml, INR 2.4. Abdominal USG is performed with pancreatitis and intra and extrahepatic bile duct dilatation; Contrast-enhanced CT: pancreas with dilation of the main duct of 12 mm and intraductal and intraparenchymal calcifications, portal vein with a diameter of 11.8 mm with stenosis of 80% of its lumen, perigastric, periesophageal and perisplenic collateral veins, stomach with thickening of its folds (14.3 mm) and splenomegaly. He developed hematemesis and melena, panendoscopy showed a large esophageal varix which was ligated, gastric varix GOV 1. Bleeding persists, so arteriography and portography were performed, which was ligated, gastric varix GOV 1. Bleeding persists, so arteriography and portography were performed, which showed: splenic vein occlusion data and partial portal vein stenosis in its proximal segment. Figure 1.

Discussion: Left portal hypertension is an etiology related to pancreatic pathologies. It should be suspected if there is a history of pancreatitis coupled with de novo digestive bleeding, splenomegaly without data of cirrhosis or hematological diseases and in a patient with IGIV.

Conclusion: It should always be considered regardless of the age of the patients, especially with gastrointestinal bleeding, in order to provide proper treatment.

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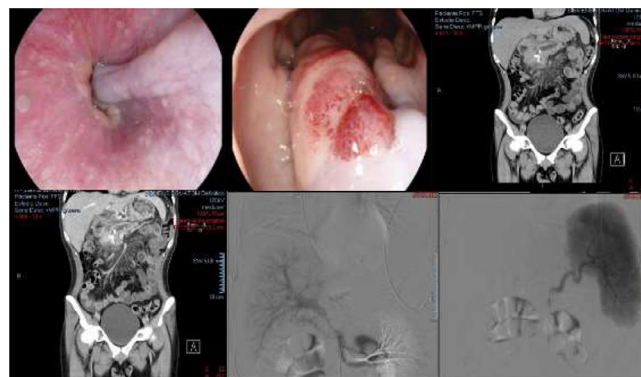


Figure 1. Endoscopy A) esophageal varix B) Thickened gastric folds with areas of subepithelial hemorrhage. Contrast-enhanced CT c) Intraductal calcifications and dilation of the main duct. d) Gastric enhancement is observed after contrast administration of perigastric veins. Arteriography and portography E) proximal portal vein stenosis F) splenic vein stenosis.

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Frequency of bleeding due to ulcer associated with H. Pylori (HP) in patients with liver cirrhosis at Hospital Juárez de México

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Introduction and Objectives: There are few clinical studies that report the prevalence of ulcers associated with H. pylori in cirrhotic patients determined by endoscopic biopsies 5% to 20% vs. 2%-4% of the general population. The risk of ulcer bleeding is higher in this