



APGAN

Commonwealth Association of Paediatric Gastroenterology & Nutrition



Bulletin

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for a better world for children...



About us

CAPGAN is the Commonwealth professional and scientific association of paediatricians which aims to promote the knowledge of, and training in, paediatric gastroenterology, hepatology and nutrition throughout the Commonwealth, especially amongst developing countries.

CAPGAN seeks to foster collaborative research in these fields, hold regular scientific meetings and be a source of authoritative advice to both national and international agencies within the Commonwealth on the problems of paediatric gastroenterology and hepatology and in particular the problems of childhood diarrhoea and malnutrition. CAPGAN exerts a positive influence as advocates for the welfare of children of the Commonwealth.

Mission & Vision

The aims of CAPGAN are to promote knowledge, research, education, and training in pediatric gastroenterology, hepatology, and nutrition throughout the Commonwealth, especially amongst developing countries.

Nominations for CAPGAN Secretary

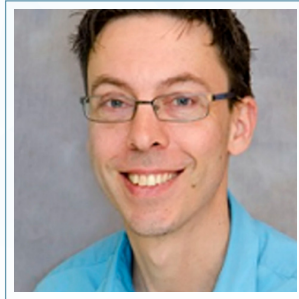
Executive Committee

Treasurer



Prof. Jay Berkley, UK/Kenya
JBerkley@kemri-wellcome.org

President



Dr. Robert Bandsma; Canada
Sponsorship and Fund Rising
robert.bandsma@sickkids.ca

Secretary



Stephen Allen
Stephen.allen@lstmed.ac.uk

Dear CAPGAN members,

Stephen Allen will be stepping down as Secretary at the forthcoming joint CAPGAN/KPA meeting in April, 2025 after more than 5 years in the post. We are inviting nominations for CAPGAN members with energy and enthusiasm to help drive the further development of our Association.

The role of Secretary; CAPGAN constitution (<https://capgan.net/constitution/>).

4.8 SECRETARY Nominations for this post will be submitted in writing by members of Council at least one month before a General Meeting, to the outgoing Secretary. They will be active members of CAPGAN, in good standing. The incoming Secretary will be elected and confirmed at the forthcoming General Meeting. The Secretary will:

- perform all duties assigned by Council and the President.
- maintain an up to date list of CAPGAN members.
- notify members of dates, times and places of General Meetings, conferences and other official meetings of CAPGAN.
- be responsible for preparing and distributing Agendas and draft Minutes of all CAPGAN meetings to the membership.
- receive and distribute, as necessary, progress reports from designated Task Groups and coordinate activities of their leaders.
- retain office until the next Conference-based General Meeting, or for a maximum of 4 years if re-elected.

A comment from Stephen: "I can thoroughly recommend this role. It places you at the heart of CAPGAN working alongside the President, Treasurer and other Council members in increasing the scope and impact of our activities. In particular, you will gain many new colleagues and friends from throughout the diverse countries of the Commonwealth.

We have made significant progress in developing our Association in the past few years; now is a good time to see some proposed activities through to fruition as well as

expand our scope even further. I would be more than happy to help my successor settle into this role and provide on-going mentorship if helpful.”

If you are interested in this role, please link with a member of Council (<https://capgan.net/council-membership-list/>) who should then submit a nomination to the Secretary (Stephen.allen@lstmed.ac.uk) before the end of February 2025. This should describe briefly your interests and work in PGHAN and also how you see developing the role of Secretary. This will allow the appointment to be completed at the CAPGAN AGM in Mombasa, Kenya in April 2025.

Please do contact me or Stephen directly if you would like further information about the post.

With best wishes,

Robert Bandsma, CAPGAN President

CAPGAN CALLING...

Calling all CAPGAN members! Please join us for our forthcoming 2 yearly conference hosted by the Kenya Paediatric Association in the fabulous Sarova Whitesands Beach Resort, Mombasa. Details regarding registration, abstract submission and also the Training-the -Colonoscopy-Trainers "hands-on" workshop (held on the morning of Tuesday April 8th) are posted below. The full programme will be posted to the CAPGAN website (<https://capgan.net/>) shortly. As usual, there are prizes awarded for both presentations and posters in Gastroenterology, Nutrition and Hepatology.







Shaping the Future:
Collaborative Approaches to Child Health and Development
 8th - 11th April 2025 | Sarova Whitesands Beach Resort, Mombasa

CAPGAN Conference | 8th - 9th April 2025

	Early	Late	On Site
KPA Members	KES 33,500	KES 38,000	KES 40,000
KPA Non Members, UNAPSA & LMIC	KES 38,500	KES 43,500	KES 45,500
International Delegates	USD 400	USD 450	USD 500
Allied Health Care Workers	KES 28,500	KES 33,000	KES 38,000
Students	KES 28,500	KES 33,000	KES 38,000
Virtual	KES 20,000	KES 20,000	KES 20,000
Day Rate	KES 11,500	KES 13,000	KES 15,000
International Day Rate	USD 100	USD 120	USD 150

Early Bird Deadline:
8th March 2025

Late Bird Deadline:
7th April 2025

On-site Dates:
8th - 11th April 2025

#KPA SciCon2025
@kenyapaeds

Call for Abstracts

Shaping the Future: Collaborative Approaches to Child Health and Development

Submit your **Abstracts** for the upcoming **KPA Annual Scientific Conference 2025!**
 Successful abstracts will be published in the Conference Booklet

To Submit:

<https://bit.ly/ASC-2025-Abstract-Submission>

Apply by: 30th January, 2025



**KENYA
 PAEDIATRIC
 ASSOCIATION**



CAPGAN Training the Colonoscopy Trainer (TCT) Taster Session

Training the Colonoscopy Trainer (TCT)

This taster session will provide independent paediatric colonoscopists involved in teaching and training with an introduction to the core skills required to deliver high quality colonoscopy training. The core principles learnt can be applied to improve teaching of other endoscopy skills. This will be a very interactive session with model-based learning.

The learning objectives:

- Understand the need to deconstruct endoscopy skills to support acquisition and learning
- Understand the concept and need for conscious competence
- Understand the need for a structured teaching episode
- Develop a framework for teaching endoscopy skills including establishing an educational contract and setting SMART objectives
- Become familiar with the use of common and consistent endoscopy language
- Understand the concept of performance enhancing training

Delegates:

Total number of delegates = 18

Faculty Tutors:

Priya Narula (Lead), Shishu Sharma and Mike Thomson.

Date:

8th April, 2025

Timing:

- Introductions and Overview 09:00
- Back to basics (loops, TI intubation, position change) 09:05
- Conscious competence 09:40
- Taking over the scope 09:50
- Use of Set-Dialogue-Closure 10:00
- Physical and Verbal Set 10:15
- Learning objectives - SMART 10:30
- Endoscopy language (timing, type, specifics) 10:40
- Performance enhancing instruction 11:00
- Break 11:15
- Paediatric endoscopy quality standards and training 11:30
- Model training (2 groups of 9) 11:45
- Summary and close 12:45 - 13:00

For the model training session – divide participants into 2 groups of 9 each with each group having 1-2 faculty member.



Looking forward to seeing you in Kenya in 2025!



Other Forthcoming Conference 2025

CSPLD 2025

8th National Conference

22-23 February 2025 | ILBS, New Delhi, India



The poster features logos for ILBS, CSPLD 2025, and ispgghan. The title is "Clinical Scenarios in Pediatric Liver Disease" with a subtitle "Pediatric Autoimmune Liver Disease : Tackling the Challenges". It lists the dates as February 22-23, 2025, and the location as Institute of Liver & Biliary Sciences, New Delhi. It identifies the Patron (Prof. Shiv K. Sarin), Organising Secretary (Rajeev Khanna), Co-organising Secretary (Vikrant Sood), and Treasurer (Bikrant Bihari Lal). A list of conference highlights includes topics like Autoimmune Hepatitis, diagnostic challenges, and liver transplant. Contact information for the Conference Secretariat is provided at the bottom.

 **CSPLD 2025** 

8th National Conference

Clinical Scenarios in Pediatric Liver Disease
"Pediatric Autoimmune Liver Disease : Tackling the Challenges"

February 22-23, 2025

Institute of Liver & Biliary Sciences, New Delhi

Patron Prof. Shiv K. Sarin Director, ILBS	Organising Secretary Rajeev Khanna
Organising Chairperson Seema Alam	Co-organising Secretary Vikrant Sood
	Treasurer Bikrant Bihari Lal

Conference Highlights

- Difficult to treat Autoimmune Hepatitis
- Diagnostic challenges & innovations
- Severe Autoimmune Hepatitis
- Immunosuppression withdrawal
- Autoimmune Overlap syndrome
- De-novo Autoimmune Hepatitis after Liver Transplant
- Research updates and Global perspectives

Conference Secretariat
Room No.: 3318, Department of Pediatric Hepatology,
Institute of Liver and Biliary Sciences (ILBS), D-1, Vasant Kunj, New Delhi
Phone No: 011-46300000, 9711143397, 9540950163
Register online at www.ilbs.in



THE 11TH ANNUAL ELITE PED-GI CONGRESS 2025

24-26 April 2025 | Abu Dhabi, UAE

ENDORSED BY:  SUPPORTED BY:   

 THE 11TH ANNUAL
ELITE PED-GI
CONGRESS 2025

 April 24-26, 2025  Beach Rotana Hotel, Abu Dhabi, UAE

[CLICK HERE TO REGISTER >](#)

116 . 17 . 15 . 38
Days . Hours . Minutes . Seconds




57th Annual Meeting of the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition 14-17 May 2025 | Helsinki, Finland



57th Annual Meeting
of the European Society for
Paediatric Gastroenterology,
Hepatology and Nutrition

14-17 May 2025 | Helsinki, Finland

www.espghancongress.org



Unlocking Hope: Launch of the South African Biliary Atresia Awareness Campaign and its achievements so far

Dr. Rachel Mlotha-Mitole

Paediatrician and Paediatric Gastroenterologist

Charlotte Maxeke Johannesburg Academic Hospital, Wits University

On behalf of the Biliary Atresia Awareness Campaign Committee, South Africa

Biliary atresia (BA) is a paediatric liver disease that comprises 40% of all aetiologies requiring paediatric liver transplantation. It is a cause of neonatal cholestatic jaundice that cannot be treated medically or by phototherapy, but rather requires surgical intervention and eventually liver transplantation. Early recognition and surgical intervention are essential as unoperated children demise by two years of age. Late presentation (>90 days of life) is common in our population allowing for rapid progression to cirrhosis and portal hypertension deeming them inoperable for a Kasai hepatoportoenterostomy. On the 19th of August 2023 the Biliary Atresia Awareness Committee under the auspices of Gauteng Provincial Solid Organ Transplant Division and the University of the Witwatersrand launched a groundbreaking Biliary Atresia Awareness Campaign, aimed at raising awareness and support for children and families affected by this rare and life-threatening liver disease. This initiative aimed to rally healthcare professionals and communities to converge in efforts towards the early detection and adept management of BA, ensuring a more promising future for our children. The campaign was well received and the message spread far and wide nationally.

A Biliary Atresia Awareness Poster, used to serve as a visual complement to our message, was unveiled on the 16th of October 2023 at Charlotte Maxeke Johannesburg Academic Hospital (CMJAH). The 16th of October is a significant date for the hospital's history and our country, as on this date we commemorate the 84th year since the demise of Charlotte Makgomo Maxeke, a South African religious leader and champion of social justice. A proposal to have this auspicious date set as a nationally recognised Biliary Atresia Awareness Day was presented to the Department of Health. We have now full support of the Department of Health to launch campaign nationally with a promise of some financial assistance. We have since October 2023, expanded our Campaign to various primary health care clinics, hospitals and various social media, webinars and conferences. Just to name a few, Lillian Ngoyi on the 15th of March 2024, Discoverers Health Clinic on the 19th of April 2024, Hillbrow Clinic on the 10th of May 2024, Chris Hani Baragwanath Academic Hospital (CHBAH) on the 8th of August 2024 and Pholosong Hospital on the 12th of September.

The medical facilities visits allowed for dissemination of posters and assisted in strengthening relationship with the referral institutions. Webinar presentations on BA Awareness were presented on “Transplant saved my baby”(30/11/23) and Paeds G-ECHO) Paediatric Gastroenterology (14/2/24). On the 26th of August 2024, we delivered a memorable presentation during an UpToSpeed conference held at the Wits Education Campus.

We aim to increase awareness nationally and beyond our borders. In progress are plans to increase dissemination of information via more media outlets (radio, television) introduce a South African BA Registry, include BA information (“Stool Chart”) in the Road to Health Booklet and organise various fund-raising functions. Biliary atresia is a manageable condition which with early referral and early surgical intervention can reduce the burden of morbidity and mortality in patients born with this condition in our country.

“Unlocking Hope, Together We Can Cope”.

The Biliary Atresia Awareness Campaign Committee, South Africa.



WHAT IS BILIARY ATRESIA?

Biliary Atresia or BA is a rare liver disease that needs immediate medical care.

If you see these signs in a baby, please tell the healthcare professional immediately!



YELLOW EYES



JAUNDICE LONGER THAN 14-21 DAYS AFTER BIRTH



WHITE STOOL FROM BIRTH



YELLOW OR DARKER SKIN

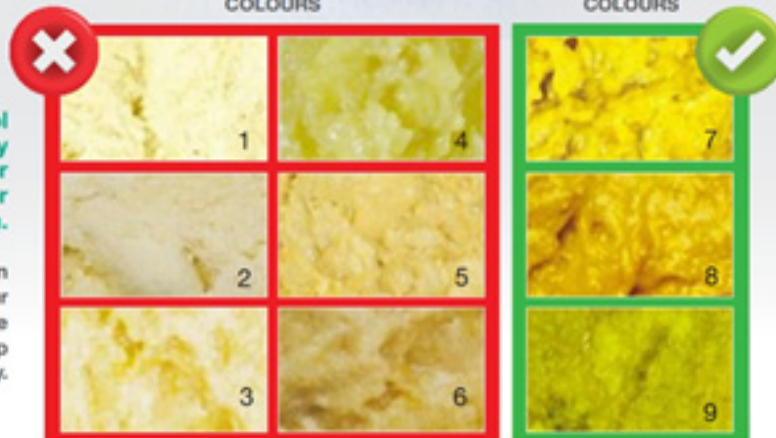


DARK URINE



ABNORMAL STOOL COLOURS

NORMAL STOOL COLOURS



Check your baby's stool (poop) colour every day for the first month after birth to screen for Biliary Atresia.

If your baby has an abnormal stool colour (colours 1,2,3,4,5,6), please seek medical help immediately.

Babies with Biliary Atresia need surgery within the 1st three months of life to survive. Don't wait – ask for help urgently if you see signs.

Unlocking Hope, Together We Can Cope.

Research update on Malnutrition

Two recent publications on malnutrition

Stephen Allen

Professor of Pediatrics,
Liverpool School of Tropical Medicine, UK

We are all familiar with the multiple short- and longer-term adverse outcomes of malnutrition on child thrival and survival. A recent analysis by The Child Health and Mortality Prevention Surveillance (CHAMPS) Network¹ re-evaluated the contribution that undernutrition makes to deaths in children 1-59 months. The data comprised clinical, verbal autopsy and post-mortem data between 2016 and 2023 from sites in seven countries (Bangladesh, Ethiopia, Kenya, Mali, Mozambique, Sierra Leone and South Africa).

The headline finding was that an expert panel considered that **malnutrition was a causal or significant condition in 632 (39.5%)** of the 1,601 deaths where minimally invasive tissue sampling post-mortem had been undertaken. In addition, malnutrition was present but not considered to be related to mortality in more children; anthropometry done post-mortem revealed that 90.1% children who died were underweight (WAZ <-2), 61.2% were stunted (LAZ <-2) and 94.1% were wasted (WLZ or MUACZ <-2). Although only a minority (85; 13.4%) children who died had HIV infection, most malnutrition-associated deaths (89.1%) were due to common infections such as lower respiratory infection, sepsis and diarrhea. Common pathogens were *Klebsiella pneumoniae*, *Streptococcus pneumoniae*, *Plasmodium falciparum* and *Escherichia coli/Shigella* spp. The authors highlight the importance of addressing both undernutrition and infection in reducing under 5 mortality.

Another familiar concept is that of the “first 1000 days” - the period from conception to age 2 years. It is important to prevent linear growth failure during this period to prevent long-term stunting (usually expressed as length-for-age z score <-2) which is estimated to occur in more than 1 in 5 of the world’s children. The first 1000 days includes 3 main periods with evidence-based interventions to prevent stunting: pregnancy, the period of exclusive breast feeding (EBF; from 0 up to 6 months) and then complementary feeding with continued breast feeding with gradual progression to the family’s usual diet (6 – 24 months). The only recommended intervention in the first 6 months after the neonatal period is EBF. Yet a recent study has highlighted that **0-3 months is the period with the highest onset of stunting**.

This finding was based on a pooled analysis of 32 longitudinal cohorts of children aged 0–24 months (total of 52,640 children) in 14 LMICs including

South Asia, sub-Saharan Africa, Latin America and Eastern Europe². Additional findings were that much stunting is already present at birth (13% overall) and a confirmation of the “first 1000 days” concept in that recovery from stunting was rare and, even amongst those who did recover, relapse was common. In addition to greater efforts to intervene during pregnancy, we need “out of the box” thinking to develop interventions alongside EBF to prevent stunting occurring early in infancy.

This e-Bulletin is released early in 2025. The WHO global nutrition target and SDG 2.2.1 to reduce stunting prevalence in under 5s from 2012 levels by 40% by 2025 will not be achieved. However, wherever in the world we work, as child health professionals, we can cite these authoritative data in our efforts to continue to advocate for improved child nutrition and to focus interventions where they will have the most impact.

References

1. Madewell ZJ, Keita AM, Das PM-G, et al. Contribution of malnutrition to infant and child deaths in Sub-Saharan Africa and South Asia. *BMJ Glob Health* 2024;9:e017262. doi:10.1136/bmjgh-2024-017262
2. Benjamin-Chung J, Mertens A, Colford JM, et al. Early-childhood linear growth faltering in low- and middle-income countries. *Nature* 621, 550–557 (2023). <https://doi.org/10.1038/s41586-023-06418-5>

Recently published article



Contents lists available at [ScienceDirect](https://www.sciencedirect.com)
Clinical Epidemiology and Global Health

journal homepage: www.elsevier.com



A Prevalence study of functional gastrointestinal disorders among the school-going adolescent population in an urban city in northern India

Darakhshan Jabeen, Shalini Verma, Shrish Bhatnagar

Clinical Epidemiology and Global Health, Volume 28, 2024, 101698,

ISSN 2213-3984, <https://doi.org/10.1016/j.cegh.2024.101698>.

(<https://www.sciencedirect.com/science/article/pii/S2213398424001945>)

Background: Functional Gastrointestinal disorders (FGIDs) are highly prevalent in the adolescent population leading to morbidity. However, their exact prevalence is not clearly known. The present study attempts to assess their prevalence in adolescent children.

Material & methods: A total of 757 school/college-going adolescents aged 10–19 years attending four different schools covered in a field study were assessed for the prevalence of FGIDs using a questionnaire based on ROME IV criteria. Socio-demographic data of the participants were also noted. Prevalence and type of FGIDs were determined. The chi-square test and Independent samples 't'-test were used to compare the data.

Results: The prevalence of FGIDs was 15.85 % (n = 120) in the adolescent population in our study. Functional abdominal pain disorders (n = 65; 54.2 %) were the most common type followed by functional defecation disorders (n = 49; 40.8 %) and functional nausea and vomiting disorders (n = 6; 5 %) respectively. (Table 1). Adolescents with FGIDs had significantly lower mean age (12.98 ± 2.30 years) and mean BMI (16.9 ± 3.2 kg/m²) as compared to those without FGIDs ($p < 0.001$). However, no significant association of sex was seen with FGID prevalence ($p = 0.755$). The present study had certain limitations due to the absence of information about dietary patterns, lifestyles, and psychosocial stress factors that could have helped to understand the cause-effect relationships of FGIDs in a better way. More as it was a cross-sectional study, a follow-up was not done on these children. It is possible that in follow-up some of these children could have been reclassified into normal or organic causes.

Table 1

Distribution of FGID according to the type of FGID (n = 120).

Type	Total FGIDs (n = 120)		% Out of total evaluated (n = 757)
	No. of with FGID	%	
H1 Functional nausea and vomiting disorders	6	5.0	0.66
H1a. Cyclic vomiting syndrome	0	0	0
H1b. Functional nausea + Functional vomiting	3	2.5	0.40
H1c. Rumination syndrome	0	0	0
H1d. Aerophagia	0	0	0
H2 Functional abdominal pain disorders	65	54.2	8.59
H2a. Functional dyspepsia	38	31.7	5.02
i) Epigastric pain syndrome	16	13.3	2.11
ii) Post-prandial distress syndrome	8	6.7	1.06
iii) Both	10	8.3	1.32
H2b. Irritable bowel syndrome	3	2.5	1.32
H2c. Abdominal migraine	1	0.8	0.13
H2d. Functional abdominal pain-not otherwise specified	23	19.2	3.04
H3 Functional defecation disorders	49	40.8	6.5
H3a. Functional constipation	49	40.8	6.5
H3b. Nonretentive fecal incontinence	0	0	
Overlapping of disorders	0	0	

Conclusions: FGIDs were found to be prevalent in school/college-going adolescents in our setting with functional abdominal pain disorders contributing to the majority of FGIDs. The Rome-IV criteria-based questionnaire is a useful tool in diagnosing FGIDs among adolescents. Our study has shown the prevalence of FGIDs in a city in northern India. It is essential to conduct community surveys to reveal the exact prevalence of FGIDs and their types at regular intervals not only from India but other parts of South East Asia as. Moreover, the children should be imparted knowledge and information regarding healthy lifestyle adaptation.

An Interesting Case

An Earring in the Esophagus of a Two-Month-Old Baby

Prof. Dr. Salahuddin Mahmud, MD

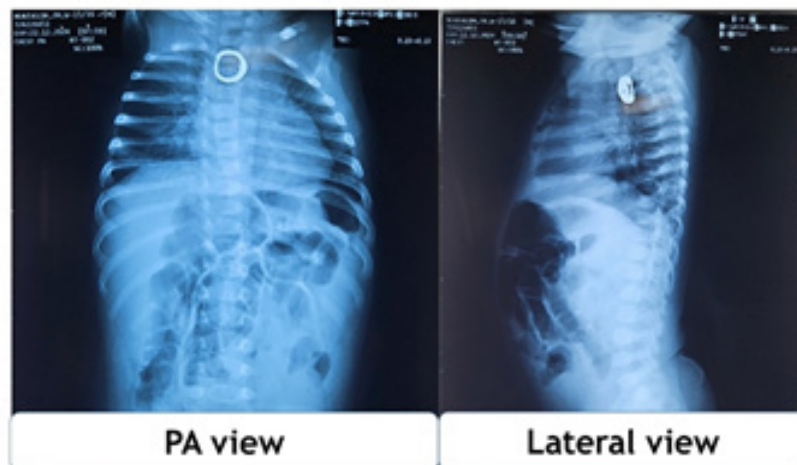
Professor

Department of Pediatric Gastroenterology

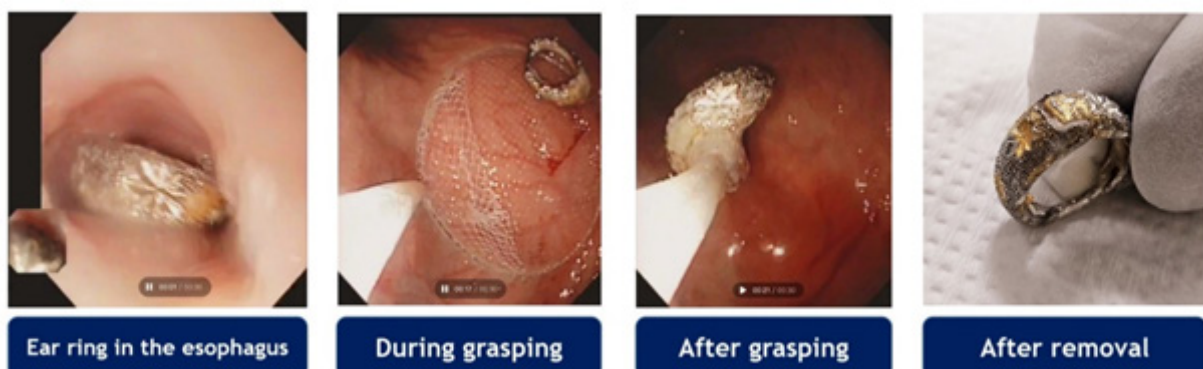
Hepatology & Nutrition

Bangladesh Shishu Hospital & Institute

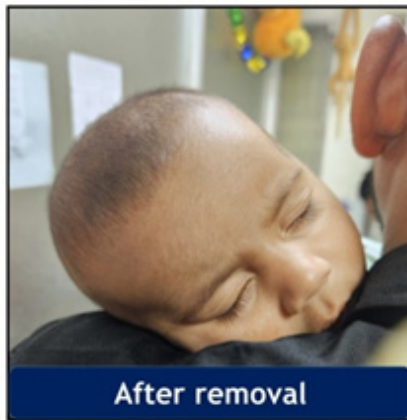
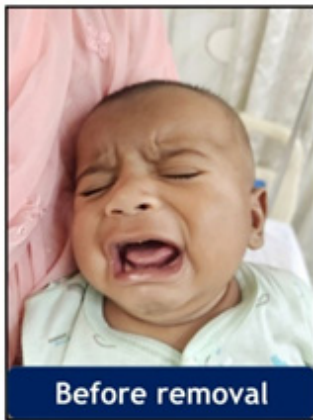
Little Infant, just 2 months and 12 days old, was lying on the bed, giggling and playing joyfully with his 5-year-old sister. Suddenly the sister held a found earring near the baby's mouth, and tragedy struck—the earring slipped and entered his mouth, lodging straight into his esophagus. This triggered repeated vomiting.



An X-ray at the nearest hospital revealed the earring's location in the esophagus. He ultimately received admission to the Bangladesh Shishu Hospital and Institute after visiting three specialized hospitals. By then, 36 hours had passed. The Pediatric Gastroenterology, Hepatology, and Nutrition Department stepped forward, preparing the endoscopy suite.



By God's boundless mercy, the Pediatric Gastroenterology, Hepatology, and Nutrition Department's expertise successfully removed the earring in just 1 minute and 30 seconds, without any complications.



The pictures were taken with the consent of the parents.

