found between urea level and CHF (p=0.072). AF was found in 13.5% of CHD patients, 61% of those patients had paroxysmal form of AF and 38.9% - permanent form. AF was more common in patients with CHF (p < 0.01). Echocardiographically assessed left atrial volume index (LAVI) was higher in patients with AF (50.6±20.7), comparing to those without AF (33 ± 10.7; p=0.01). We also found that cardiac output was lower in patients with AF (52.5±11.5) than in those without AF (60.7±9; p=0.046). Average score of CHA2DS2-VASc in patients with AF (4.9±1.7) was higher than in patients without AF (2.7±1.7; p <0.001). The average HAS-BLED score was 4.1 ± 1 in patients with AF, and 3.6 ± 1 in those without AF, no statistically significant difference was displayed (p = 0.062).

**Conclusions.** CHD is a common finding in CHD patients. Arterial hypertension and elevated BMI are modifiable risk factors of CHF in CHD patients, so strict control of hypertension and weight control is mandatory. Patients with CHF and elevated left atrial volume index AF can be expected. CHD patients have an increased risk of both thromboembolism and bleeding, therefore intensive surveillance of the patient is necessary, even if the patient does not have AF.

**NONINVASIVE PREDICTORS OF PRESENCE AND SIZE OF ESOPHAGEAL VARICES IN PATIENTS WITH HCV RELATED LIVER CIRRHOSIS**

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**Key words:** Fibroscan, serum fibrosis scores, esophageal varices.

**Introduction:** Portal hypertension is related to liver fibrosis, therefore noninvasive liver fibrosis markers could predict esophageal varices. These predictors of varices could reduce the number of screening upper gastrointestinal endoscopies.

**Aim:** To compare different serum fibrosis scores and transient elastography in prediction of esophageal varices and to determine cut-off values for diagnosing large varices in patients with HCV related liver cirrhosis.
Results: Of 111 patients enrolled in the study, 42 (37.8%) had no esophageal varices (EV), 43 (38.7%) had small varices and 26 (23.4%) had large varices by endoscopy. Liver stiffness measured by fibroscan was significantly higher in patients with EV compared with patients without (30.28 kPa vs 20.41 kPa  p< 0.001). The presence of EV was predicted with the cut-off value of liver stiffness higher than 32.4 kPa (sensitivity 44.9%, specificity 88.1%). The APRI score was the best among all the serum scores for diagnosing EV. The area under receiver operating characteristic curve (AUC) was 0.785, cut-off value >1.04 (sensitivity 56.5%, specificity 90.5%). For prediction of large EV liver stiffness value was determined higher than 36.3 kPa (sensitivity 53.7%, specificity 86.1%). The best AUC for diagnosing large varices was calculated of the FIB-4 score (0.823). For FIB-4 score higher than 5.98, the sensitivity was 88.5% and specificity 72.1%.

Conclusions: Transient elastography may be considered as non-endoscopic predictor for the diagnosis of esophageal varices and management of large varices with value higher than 32.4 kPa and 36.3 kPa, respectively. Serum fibrosis scores could also be used as good predictors, especially APRI and FIB-4 scores in cirrhotic patients.

CLINICAL EXPERIENCE WITH USAGE OF PERCUTANOUS ENDOSCOPIC GASTROSTOMY METHOD IN PAULS STRADINS CILINICAL UNIVERSITY HOSPITAL

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Key words. Percutaneous endoscopic gastrostomy, gastrostomy, endoscopy, mortality.

Introduction. Percutaneous Endoscopic Gastrostomy (PEG) was made for the first time in 1980 at Cleveland University Hospital (USA), and from that time it became the method of choice for ensuring long-time enteral feeding as an alternative for surgical gastrostomy. It is minimally invasive, relatively fast method with low expenses.

First PEG at Pauls Stradins Clinical University Hospital was made in 1994. During last twenty years PEG usage has increased and it has become the