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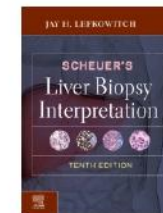
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Scheuer's Liver Biopsy Interpretation, Tenth Edition

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Lebowitz, Jay H., MD

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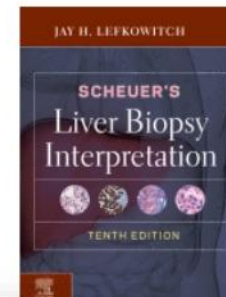
Childhood Liver Disease and Metabolic Disorders

Jay H. Lefkowitz MD

Scheuer's Liver Biopsy Interpretation, Chapter 13, 288-322

Introduction

Paediatric liver biopsies become clinically apparent in the first few months of life as neonatal liver disease, the pathology of which suggests the diagnosis. In many instances, assays of metabolic enzymes and products in serum and liver tissue take diagnostic precedence over routine histopathological interpretation. Electron microscopy may be required to assess the structure of organelles or storage material in hepatocytes or Kupfer cells, particularly when lysosomal storage disorders are being considered. Consultation with investigators dealing with mitochondrial diseases, mutations of bile-salt transport proteins¹ and expression of proteins involved in blood vessel and bile-duct morphogenesis (e.g. jagged proteins and Notch receptors) should be considered if special studies are needed to determine the cause of neonatal cholestasis. Childhood liver tumours are discussed in Chapter 11.



Chapter 13 - Childhood Liver Disease and Metabolic Disorders

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CHAPTER

13

Childhood Liver Disease and Metabolic Disorders

Introduction

Paediatric liver biopsies present a unique set of diagnostic problems for the pathologist, many of which become clinically apparent in the first few months of life as neonatal cholestasis.¹ Among the important disorders one must consider in evaluating neonatal liver biopsies are extrahepatic biliary atresia, paucity of intrahepatic bile ducts (syndromic and non-syndromic types), metabolic diseases, viral hepatitis and the hepatic effects of parenteral nutrition (Table 13.1). Common to many of these conditions are the histological features of cholestasis and giant-cell hepatitis (formation of multinucleated hepatocytes). Because these features are not specifically diagnostic of any one neonatal liver disease, the pathologist must be acquainted with other biopsy changes by which to establish or suggest the diagnosis. In many instances, assays of metabolic enzymes and products in serum and liver tissue take diagnostic precedence over routine histopathological interpretation. Electron microscopy may be required to assess the structure of organelles or storage material in hepatocytes or Kupfer cells, particularly when lysosomal storage disorders are being considered. Consultation with investigators dealing with mitochondrial diseases, mutations of bile-salt transport proteins¹ and expression of proteins involved in blood vessel and bile-duct morphogenesis (e.g. jagged proteins and Notch receptors) should be considered if special studies are needed to determine the cause of neonatal cholestasis. Childhood liver tumours are discussed in Chapter 11.

Diagnostic approach to neonatal liver biopsy

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FULL TEXT ARTICLE

The uncertainties of monitoring progress towards achieving global nutrition targets

Anura V Kurpad and Harshpal Singh Sachdev

Lancet, The, 2024-12-21, Volume 404, Issue 10471, Pages 2488-2489, Copyright © 2025 Elsevier Ltd

The 65th World Health Assembly in 2012 established six global nutrition targets (GNTs) related to low birthweight, exclusive breastfeeding, child growth (stunting, wasting and overweight), and anaemia in women of reproductive age as key indicators of maternal and child health.¹ Therefore, evaluations of progress towards these targets, and their forward projections are of great interest to policy makers, scientists, and clinical practitioners. Although some other progress towards these targets,² the recent analysis by the Global Nutrition Target Collaborators, as part of the Global Burden of Disease Study (GBD),³ is a comprehensive effort to estimate the prevalence of GNT indicators and their attributable burden at a regional, national, and global level from 2012 to 2021, with projections to 2050 in 204 countries and territories, using GBD

Target Collaborators' study, anthropometric indicators of undernutrition showed that, by 2030, only 94 of 204 countries and territories globally will meet one of the six targets, 21 will meet two targets, and 89 will meet no targets. They projected that seven of the six targets for exclusive breastfeeding, 28 for child stunting, 101 for child wasting, 101 for low birthweight, child overweight, and anaemia in females of reproductive age. The burdens of low birthweight, child stunting, and child wasting in many low-income countries (LMICs) are substantial and will require targeted interventions.

References

Progress towards achieving global nutrition targets

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Comment



The uncertainties of monitoring progress towards achieving global nutrition targets



Published online
December 9, 2024
[https://doi.org/10.1016/S0140-6736\(24\)01180-9](https://doi.org/10.1016/S0140-6736(24)01180-9)
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The 65th World Health Assembly in 2012 established six global nutrition targets (GNTs) related to birthweight, exclusive breastfeeding, child growth (stunting, wasting and overweight), and anaemia in women of reproductive age as key indicators of maternal and child health.¹ Therefore, evaluations of progress towards achieving these targets, and their forward projections are of great interest to governments, public health policy makers, scientists, and clinical practitioners. Although some other bodies have reported on progress towards these targets,² the recent analysis by the Global Nutrition Target Collaborators, as part of the Global Burden of Disease Study (GBD),³ is a comprehensive effort to provide changes in the prevalence of GNT indicators and their attributable burden at a regional, national, and global level from 2012 to 2021, with projections to 2050 in 204 countries and territories, using GBD 2021 data.⁴

In the Global Nutrition Target Collaborators' study, anthropometric indicators of undernutrition showed variable decline across countries, although this was slow and insufficient to meet most targets.⁵ The collaborators projected that, by 2030, only 94 of 204 countries and territories globally will meet one of the six targets, 21 countries will meet two targets, and 89 will meet

Limitations of the analyses, mostly acknowledged by the collaborators,⁶ still deserve attention. Importantly, the raw data informing indicator prevalence are of variable quality and sometimes incomplete. Estimates of anaemia from LMICs are invariably based on capillary blood, whereas WHO guidelines recommend venous blood testing.⁷ This distinction can be clinically significant—for instance, in India, venous blood-based anaemia prevalence in children aged 1–19 years was roughly half of the capillary blood prevalence in similar national surveys.⁸ Thus, segregating analyses for venous and capillary blood collection would have been informative. Also, International Obesity Task Force (IOTF) BMI and age-based cutoffs in children aged 2–4 years were used to model prevalence of overweight,⁹ which cannot be directly extrapolated to the extended 2030 target of 3% prevalence in children younger than 5 years, which used the WHO weight-for-height Z-score definition. Quantifying the potential biases that could arise from this disparity in overweight metrics and age groups evaluated in various settings will be difficult for policy makers. Finally, the collaborators modelled monotonically decreasing priors over time, without specifying the evidence base for this decision. The rate of decline will slow down with decreasing prevalence of

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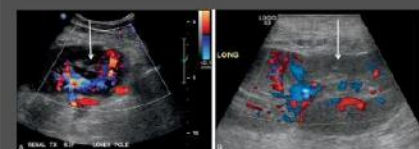
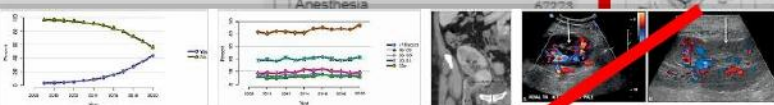
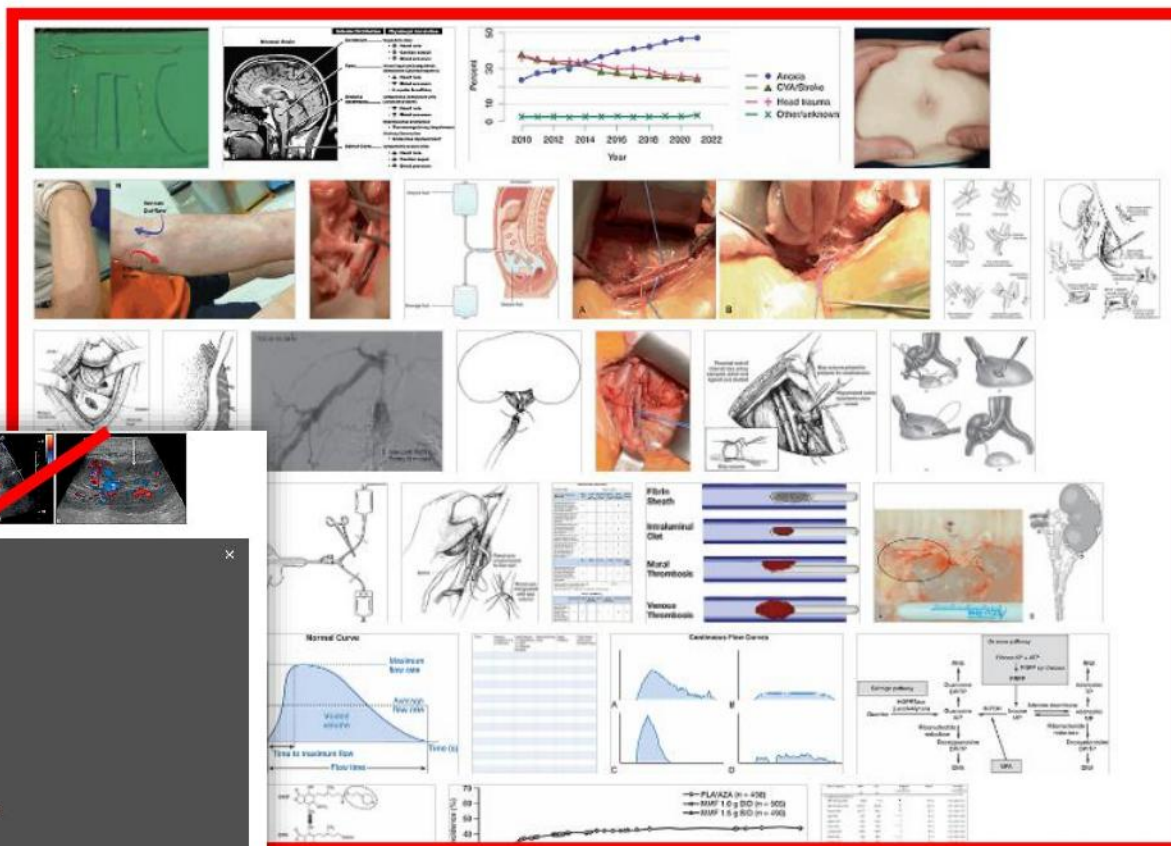
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IMAGE

Vascular and Lymphatic Complications After Kidney Transplantation

Kidney Transplantation: Principles and Practice

Knight, Simon R. © 2008.

Fig. 28.14 Color Doppler ultrasound demonstrating wedge-shaped anovascular area (arrow) of lower pole of a deceased donor kidney transplant with four renal arteries, one of which was shown to be thrombosed at the time of subsequent transplant exploration. (A) Seven days after transplantation. (B) Scarred infarcted area 3 months later.

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2 Books for 'sleep'

CLINICAL OVERVIEW

Delayed Sleep/Wake Phase Disorder

DSWPD (delayed sleep/wake phase disorder) is a common circadian rhythm disorder characterized by an intrinsic sleep schedule that does not align with personal or societal demands. Condition is most common in adolescents and young adults with an esti...

Bean,, Steven, DO; Brown,, William, PhD; ...Show all. Updated February 19, 2024. © 2021.

Jump to [Summary](#) [Diagnosis](#) [Workup](#) [Treatment](#)

CLINICAL OVERVIEW

Spike Wave Activation in Sleep

DEE- and EE-SWAS (developmental epileptic activation in sleep] and epileptic encephalopathy syndromes characterized by neurocognitive...

Gupta, Siddharth, MBBS; Kelley, Sarah Amin...

CLINICAL OVERVIEW

Insufficient Sleep in Children

Insufficient sleep is defined as quantity of...

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Outline

- Summary
- Basic Information
- Diagnosis
- Workup
- Differential Diagnosis
- Treatment
 - Approach to Treatment
 - Nondrug and Supportive Care
 - Drug Therapy
 - Persistent or Recurrent Disease
- Special Considerations
- Follow-Up

Treatment

Approach to Treatment

- Behavioral adjustments are the primary approach to DSWPD management (delayed sleep/wake phase disorder)
 - Management involves gradually shifting sleep and wake times earlier to meet societal and work-related demands
- Timed melatonin administration and light therapy to help adjust the body's circadian rhythm are adjunct recommendations for patients who do not respond well to behavioral methods alone
- More research is needed in this area; a paucity of information and no clinical practice guideline are available

Nondrug and Supportive Care

- Behavioral modifications
 - Optimize and maintain sleep hygiene behaviors
 - Prioritize consistent sleep habits