

3rd Issue

# SASLT NEWSLETTER

September 2022

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# HCV elimination in Saudi Arabia:

## Where Do We Stand?

With the availability of oral direct acting antiviral therapy for hepatitis C virus (HCV), global elimination of HCV becomes possible. In 2016, the World Health Organization (WHO) set the roadmap for the elimination of viral hepatitis. The WHO targets include reduction of new infections by 90 percent, diagnosing 90 percent of infected patients and treating 80 percent of eligible people, by 2030. Since then, national programs with a vision toward HCV elimination have been initiated in countries around the globe. In Saudi Arabia, the Ministry of Health launched a nationwide screening and treatment program. Anti-HCV medications, despite the high cost, are provided free of charge to treat infected patients, whether they be Saudi citizens or non-Saudi residents. The emergence of the coronavirus pandemic in late 2019 impacted the national and global efforts toward HCV elimination. In this issue of the SASLT newsletter, we interview Dr. Abdulah Assiri, the Deputy Minister of Health for Preventive Health who has been leading the effort towards HCV elimination in the country. Dr. Assiri answered key questions regarding the Kingdom's vision for HCV elimination.

### **What is the prevalence of HCV, demographic distribution, and main transmission routes in Saudi Arabia?**

Based on recent MOH data for hepatitis C, the prevalence of hepatitis C in KSA is (0.23%) with slight male predominance. Known modes of transmission of HCV in Saudi Arabia are similar to other high-income countries. Case investigations do not always reveal the likely source, however, history of IVDU and dental procedures especially in



private clinics are increasingly reported. We noticed a significant decline in new HCV acquisition in hemodialysis units. Advances in blood products transfusion safety have virtually eliminated transfusion-related HCV in Saudi Arabia.

Based on recent MOH data for hepatitis C, the prevalence of hepatitis C in KSA is (0.23%) with slight male predominance.

### **What are the estimated healthcare and economic burdens of HCV in Saudi Arabia?**

Based on previous data, HCV-related health costs in Saudi Arabia until 2030 were estimated to be SAR 18 billion including direct and indirect health costs for treating early HCV cases, for all HCV cases, and HCV-related complications. We are currently recalculating the economic burden of HCV, especially after an aggressive national screening and treatment program was launched in 2018.

## **What is the current strategy for HCV elimination in Saudi Arabia? Who are the key stakeholders in the implementation?**

Elimination of HCV is based on case finding via an aggressive national screening program and expanded access to care where family physicians have full privileges to test and treat with DAA agents in conjunction with a strategy to prevent new infections. In addition to the screening activities, HCV cases are captured through, a premarital screening program, enhanced screening for special populations such as dialysis patients, blood donors, IVDU, prisoners, and selected hospital-based screenings. Saudi Arabia also made hepatitis screening and treatments free to all citizens and residents, both Saudi and non-Saudi. Different stakeholders are involved in this initiative including all Governmental, non-governmental, and private health care sectors. Relevant non-governmental organizations (NGOs) are also engaged in screening and treatment of hepatitis C. We believe that the role of NGOs is especially important in accessing difficult-to-reach communities.

## **How does Saudi Arabia compare to the rest of the world regarding efforts for HCV elimination?**

The Ministry of Health has worked with the Center for Disease Analysis (CDA) Foundation (a non-profit organization), to assess the baseline points and set progress targets using epidemiological data, modeling tools, and decision analytics. The first round was completed in 2014 and we are in the process of updating the inputs. Changes in the landscape of the labor market led to changes in HCV prevalence. Based on the 2014 modeling, Saudi Arabia is expected to reach the goal of diagnosing 90% of HCV infections and treating 80% of viremic HCV by 2048, reducing the incidence by 90% in 2049 and reaching the overall elimination goal by 2051. The second round of modeling is expected to significantly change the two elimination target years.

## **Since most known cases have been treated, who will be targeted for HCV screening?**

Since the launch of the test-and-treat program in 2014, we believe that most cases that have a record of HCV infection in Saudi Arabia have been assessed for treatment or treated. In 2018, a mass community-wide screening was launched. The aim is to screen everyone above the age of 40 years at least once in their lifetime. In 4 years, 10 million people have been screened for HCV.

## **What are the expected benefits to the healthcare system by HCV eliminating programs?**

Large-scale HCV screening, subsequent linkage to HCV care, and easy access to DAA are essential for elimination and will likely cost less than 30% of the direct HCV health costs.

In 2018, a mass community wide screening was launched. The aim is to screen everyone above the age of 40 years at least once in their lifetime.

## **What are the obstacles to eliminating HCV, and how can we overcome them?**

Finding HCV cases is becoming more difficult with time. Incorporating community-wide HCV screening is a difficult task that requires intensive resources and coordination, but it seems necessary to reach the elimination goals. The shift of cases is more towards difficult-to-reach communities including illegal immigrants, expatriates with inadequate medical insurance coverage, and IVUDs.



**Dr. Majid** Alsahafi

# Validation of the EVendo score for the prediction of varices in cirrhotic patients

Alswat K, et al. Saudi J Gastroenterol 2022;28(5):378-384. doi: 10.4103/sjg.sjg\_624\_21.

One of the leading causes of liver-related mortality in patients with cirrhosis is variceal bleeding. The prevalence of gastroesophageal varices (GEV) increases with advanced stages of cirrhosis. Therefore, patients with cirrhosis should undergo screening endoscopy to identify high-risk varices (HRV) that require treatment, such as non-selective beta blockers or endotherapy. Several studies, however, have shown that most patients with cirrhosis having screening endoscopies have no GEV. Thus, recent guidelines recommend using non-invasive tools to identify patients with varices needing treatment (VNT). In this study, the authors aimed to validate the performance of the new novel EVendo score as a noninvasive screening tool for predicting GEV and VNT in cirrhotic patients in a real-world clinical setting.

A total of 103 patients underwent GEV screening; most had hepatitis C infection, followed by nonalcoholic fatty liver disease as a cause of cirrhosis. There were 66 (64%) and 12 (11.65%) patients with GEV and VNT, respectively. An EVendo score of  $\leq 3.90$  identified patients with no GEV and VNT with sensitivities of 82% and 83% and specificities of 57% and 34%, respectively. VNT had a negative predictive value (NPV) of 94%. Furthermore, with an EVendo score of 3.90, 20.38% of patients were spared screening endoscopy with a miss rate of 1.9% for VNT. In patients with Child-Turcotte-Pugh (CTP) A, the Baveno VI criteria ruled out GEV and VNT with sensitivities of 89% and 100%, specificities of 43% and 26%, and NPVs of 71% and 100%, respectively. The Baveno VI criteria could spare 21.35% of endoscopies with a missing rate of VNT of 0%.

Dr. Alswat concluded that this study demonstrated the excellent performance of the EVendo score and the Baveno VI criteria in screening patients with

cirrhosis for GEV and VNT. Compared with Baveno VI criteria, the EVendo score uses easily accessible clinical and laboratory data and has a better-spared endoscopies rate.

## Hepatic fibrosis changes in patients with chronic hepatitis C infection who respond to direct-acting antivirals

Alswat K, et al. Ann Saudi Med 2022;42(2):89-95. doi: 10.5144/0256-4947.2022.89.

Hepatitis C virus (HCV) infection is a common cause of cirrhosis and its complications, such as liver decompensation and hepatocellular carcinoma. There is increasing evidence that HCV treatment and viral eradication (defined by a sustained virological response [SVR]) improve clinical outcomes and reduce mortality. Interferon-based therapy and, more recently, direct-acting antiviral (DAA) therapy have been associated with histological improvements in follow-up biopsies after patients achieve SVR. The authors of this study highlight that studies assessing long-term changes in liver fibrosis post-treatment with DAA are limited. Thus, they used multiple noninvasive methods, APRI, FIB-4, and liver stiffness measurements (LSM) by Fibroscan, to evaluate the long-term effects of virus clearance on liver fibrosis among chronic hepatitis C responders to DAA therapy.

A total of 172 HCV treatment responders were included with a mean (SD) age of 54.1 (14.1), body mass index of 28.8 (6.5) kg/m<sup>2</sup> at baseline, and 96 (55.8%) females. The majority of patients had genotype 4 (n=125, 73%), and the mean follow-up

was 141 (57.9) weeks. Alanine aminotransferase ( $P < 0.001$ ), aspartate aminotransferase ( $P < 0.001$ ), and albumin levels ( $P = 0.01$ ) changed significantly from baseline. Among 62 patients with baseline cirrhosis, 24.6% improved by one stage, 23.1% improved by two stages, 4.6% improved by three stages, and 6.2% improved by four stages during follow-up. Fibrosis scores remained the same in 38.4% of cases (baseline and follow-up fibrosis scores), and only 3.1% showed an increase in fibrosis. A total of 59 patients (34.3%) had low fibrosis (F0-F1), and 113 (65.7%) had significant fibrosis ( $\geq F2$ ). Transaminases, APRI, and FIB-4 levels improved significantly in both groups, while LSM declined significantly only in patients with significant and advanced fibrosis.

In this study, Alswat and colleagues found that the clearance of HCV with DAAs was associated with significant improvement in liver fibrosis as measured by noninvasive methods, supporting the concept of post-treatment fibrosis regression.

## Lower prevalence of hepatic fibrosis in low viremic hepatitis B patients with fluctuating HBV DNA levels

Sanai F, et al. Saudi J Gastroenterol 2022;28(5):341-347. doi: 10.4103/sjg.sjg\_48\_22.

It is estimated that approximately 292 million people worldwide are chronically infected with the hepatitis B virus (HBV), which is a leading cause of cirrhosis, hepatocellular carcinoma (HCC), and liver-related death. Patients with HBV inactive carrier states require periodic liver enzyme and HBV DNA monitoring, and fluctuations in HBV DNA over time can interfere with the accurate diagnosis of inactive carrier states. In this study, Sanai and colleagues wanted to address a common and clinically relevant “gray area” of chronic hepatitis B infection. All regional and international HBV

guidelines are silent on this group of patients. Therefore, they evaluated patients with low - intermediate range viremia (2000 - 20,000 IU/ml) with fluctuating HBV DNA levels. A total of 234 untreated HBeAg-negative carriers were included, of which 73 had fluctuating HBV DNA levels above or below 2000 IU/mL and 161 without fluctuations. Patients without fluctuating HBV DNA were further analyzed based on those with persistently low ( $< 2,000$  IU/mL,  $n = 137$ ) and higher HBV DNA (2,000–20,000 IU/mL,  $n = 24$ ). Hepatic fibrosis (assessed by transient elastography) was correlated with virologic and biochemical profiles. The mean age was  $47.8 \pm 11.1$  years, of whom 45.7% were male. During a median of 60 months of follow-up, 31.2% of patients had a mean of  $1.6 \pm 0.9$  fluctuations in HBV DNA. Patients with fluctuating viremia had higher quantitative HbsAg and HBV DNA than those without fluctuations. Males were less likely to experience fluctuations in HBV DNA (37.0%,  $P = 0.071$ ). Fluctuations occurred more frequently in those with predominantly higher HBV DNA levels (26.0%) than those without fluctuations (14.9%;  $P = 0.030$ ).

Sanai et al. concluded that this study highlighted that minor HBV DNA level fluctuations are common. Such patients can be characterized safely as inactive HBV (chronic hepatitis B infection) with no increase in hepatic fibrosis rates. This puts to rest the long-standing confusion over how to categorize these patients and whether they actually meet the criteria for initiating antiviral therapy.



**Dr. Mona H. Ismail**

# Tremelimumab plus Durvalumab in Unresectable HCC

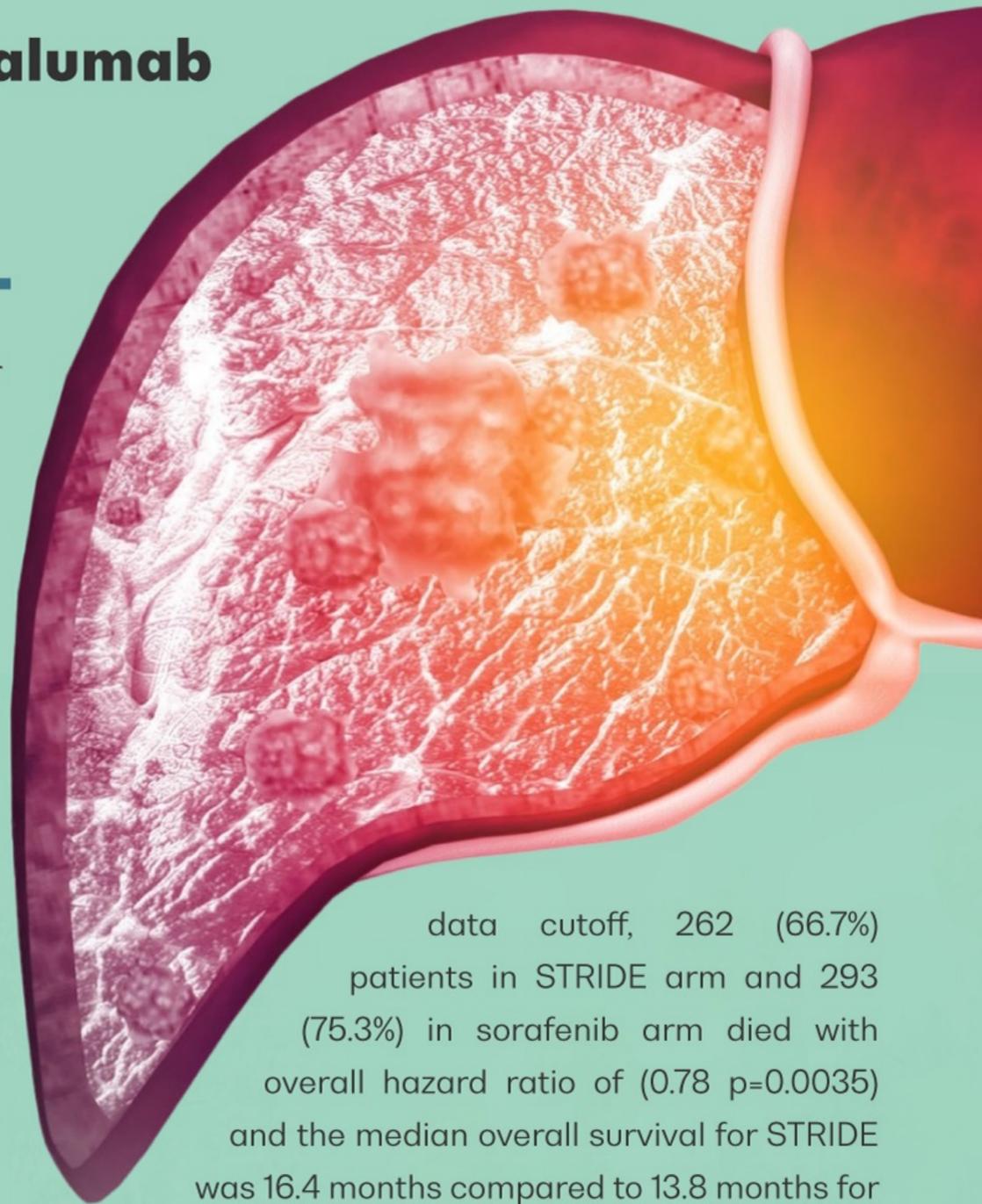
Abou-Alfa G, et al. NEJM Evid 2022.  
doi:<https://doi.org/10.1056/EVIDoa2100070>

Immuno-oncology (IO) for hepatocellular carcinoma (HCC) is a hot topic in hepatology. Few agents have shown promising results in clinical trials and many agents are under investigation. The Himalaya trial is a phase 3, randomized, open-label, sponsor-blinded, multicenter clinical trial that combined Tremelimumab, a cytotoxic T lymphocyte-associated antigen 4 (CTLA-4) inhibitor with durvalumab, a programmed cell death ligand-1 (PDL-1) inhibitor, where the combination had shown promising clinical activity and safety in a previous phase-2 trial.

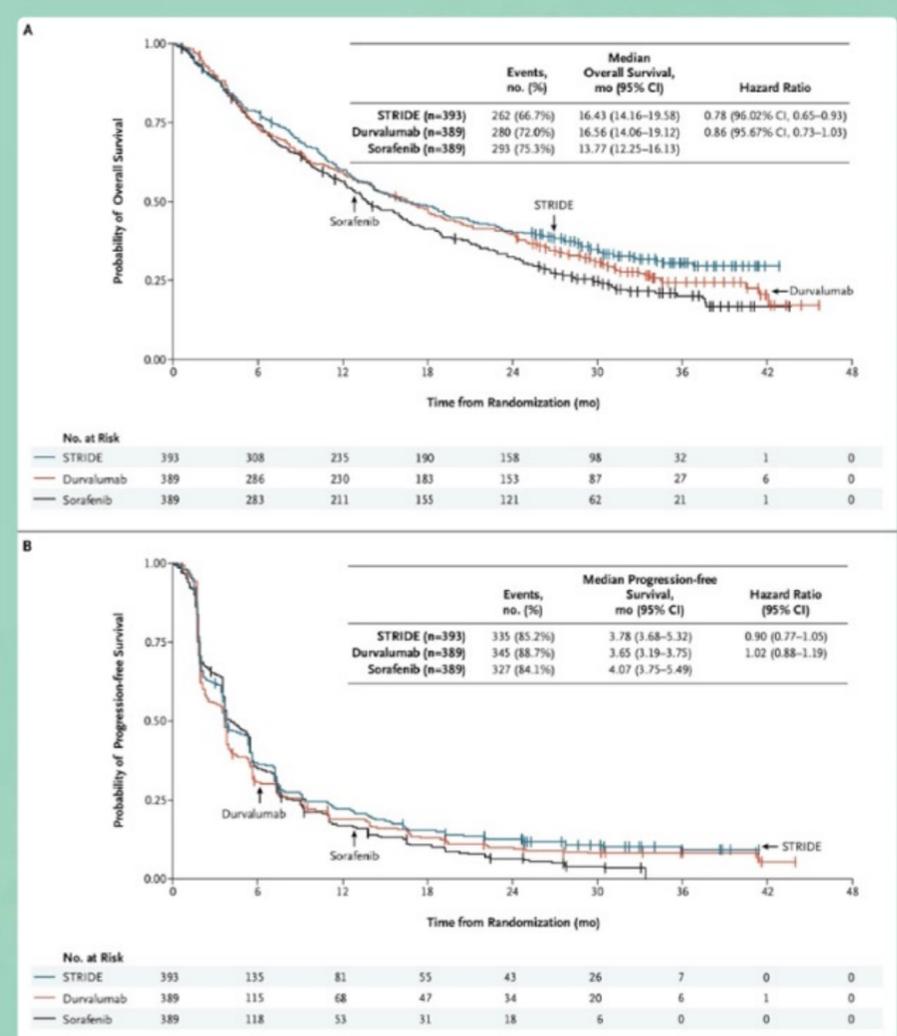
The trial enrolled adult patients with histologically confirmed unresectable HCC and no previous systemic treatment and not eligible for locoregional therapy. Only patients with Child-Pugh Score A and Eastern Cooperative Oncology Group (ECOG) performance status score of 1-2 were eligible for the trial. Subjects were randomly assigned to receive one of three regimens: tremelimumab (300 mg, one dose) plus durvalumab (1500 mg every 4 weeks) a regimen called STRIDE, durvalumab (1500 mg every 4 weeks), or sorafenib (400 mg twice daily). The primary objective was overall survival for STRIDE versus sorafenib. Noninferiority for overall survival for durvalumab versus sorafenib was a secondary objective.

Treatment continued until progression, unacceptable toxicity, consent withdrawal or other discontinuation criteria were met. Tumor assessment was done by CT scan or MRI using RECIST criteria. The primary outcome was overall survival defined as time from randomization until death from any cause.

The study enrolled 1171 patients from 16 countries. At



data cutoff, 262 (66.7%) patients in STRIDE arm and 293 (75.3%) in sorafenib arm died with overall hazard ratio of (0.78  $p=0.0035$ ) and the median overall survival was 16.4 months compared to 13.8 months for sorafenib. Figure 1 shows the Kaplan-Meier estimates of overall survival in the intention to treat population. Additionally, durvalumab monotherapy was noninferior to sorafenib, with a median overall survival of 16.6 months in the durvalumab arm.



In conclusion, STRIDE regimen demonstrated statistically significant improvement in overall survival versus sorafenib with number needed to treat of 11. Durvalumab monotherapy was noninferior to sorafenib for overall survival. These results further expand the treatment horizon for HCC, offering less toxicity, which will likely translate into more favorable outcomes in these patients.

## Outcomes of pregnancy in autoimmune hepatitis

Wang, CW, et al. *Hepatology*. 2022;75:5–12.  
doi:10.1002/hep.32132

Many gaps arise while discussing the combination of pregnancy and autoimmune hepatitis (AIH) whether between physicians and patients or amongst physicians themselves. These include the influence of AIH on pregnancy outcomes, the impact of pregnancy on the disease behavior and the potential toxicity of medications used for AIH treatment. Wang et al, reported the outcomes of pregnancy in a large series of AIH patients from United States. The authors aimed to evaluate temporal trends in AIH pregnancies and determine whether pregnancies with AIH are independently associated with adverse maternal and perinatal outcomes.

A retrospective search was performed of US-Based National inpatient sample database from 2008 to 2016 to identify adult pregnancies with AIH, other chronic liver disease (CLD) or no CLD. Maternal pregnancy outcomes and perinatal outcomes were reported. The analysis included 18,595,345 eligible pregnancies, of whom 935 pregnancies were with AIH (6.4% with cirrhosis), 120,100 pregnancies with other chronic liver diseases (0.7% with cirrhosis) and 18,474,310 pregnancies without liver disease,

with mean ages of 30, 30 and 29 years respectively.

**Table 1: Prevalence of maternal and perinatal outcomes by liver disease status in pregnancy**

	Prevalence, n (%)			p values (vs. AIH)	
	AIH n = 935	Other CLD n = 120,100	No CLD n = 18,474,310	Other CLD	No CLD
<b>Maternal outcomes, n (%)</b>					
GDM	160 (17.1)	10,410 (8.7)	1,289,515 (7.0)	<.001	<.001
Gestational HTN	20 (2.1)	4235 (3.5)	717,765 (3.9)	0.31	0.22
Hypertensive complications (pre-eclampsia, eclampsia, and/or HELLP syndrome)	80 (8.6)	5245 (4.4)	712,920 (3.8)	0.005	0.001
Cesarean section	295 (32.2)	44,510 (37.4)	6,075,733 (33.0)	0.14	0.79
Postpartum hemorrhage	30 (3.2)	5595 (4.7)	589,580 (3.2)	0.35	0.99
Maternal death	0 (0.0)	40 (0.03)	920 (0.005)	0.80	0.93
<b>Perinatal outcomes, n (%)</b>					
Preterm birth (<37 weeks)	80 (8.6)	8355 (7.0)	846,620 (4.6)	0.39	0.01
Fetal growth restriction	25 (2.7)	4155 (3.5)	372,885 (2.0)	0.56	0.52
Large for gestational age	<10 (1.1) <sup>a</sup>	2195 (1.8)	489,760 (2.7)	0.44	0.18
Fetal death	<10 (1.1) <sup>a</sup>	1130 (0.9)	127,720 (0.7)	0.57	0.80

**Table 2: Prevalence of maternal, perinatal, and liver-related outcomes in pregnancies with cirrhosis, by liver disease etiology (n = 905)**

	Prevalence, n (%)		p values
	AIH n = 60	Other CLD n = 845	
<b>Maternal outcomes, n (%)</b>			
GDM	15 (25.0)	95 (11.2)	0.15
Gestational HTN	<10 <sup>b</sup>	50 (5.9)	0.33
Hypertensive complications (pre-eclampsia, eclampsia, and/or HELLP syndrome)	<10 <sup>b</sup>	145 (17.2)	0.10
Cesarean section <sup>a</sup>	30 (60.0)	470 (58)	0.92
Postpartum hemorrhage	<10 <sup>b</sup>	90 (11.2)	0.80
Maternal death	<10 <sup>b</sup>	<10 <sup>b</sup>	0.71
<b>Perinatal outcomes, n (%)</b>			
Preterm birth (<37 weeks)	15 (25.0)	130 (15.4)	0.37
Fetal growth restriction	<10 <sup>b</sup>	35 (4.1)	0.43
Large for gestational age	<10 <sup>b</sup>	<10 <sup>b</sup>	0.06
Fetal death	<10 <sup>b</sup>	25 (3.0)	0.32
<b>Liver-related outcomes, n (%)</b>			
Decompensated cirrhosis	<10 <sup>b</sup>	155 (18.3)	0.89
Bleeding varices	<10 <sup>b</sup>	<10 <sup>b</sup>	0.01
Nonbleeding varices	20 (33.3)	130 (15.4)	0.08
Hepatic encephalopathy	<10 <sup>b</sup>	45 (5.3)	0.12
Ascites	0 (0%)	45 (5.3)	0.36
Spontaneous bacterial peritonitis	0 (0%)	<10 <sup>b</sup>	0.70
Portal HTN	20 (33.3)	185 (21.9)	0.32
Hepatorenal syndrome	0 (0%)	45 (5.3)	0.35

The authors concluded that the rate of pregnancy in women with AIH remained stable, and that AIH is associated with notable maternal and perinatal risks. Whether these risks are influenced by steroid use and/or disease activity warrants evaluation.

This study has addressed crucial points relating to pregnancy and AIH combination, and has obvious points of interest for readership in Saudi Arabia. Although the prevalence of AIH in Saudi Arabia may be similar to USA, studying the outcomes of pregnancy in these patients would be advisable due to racial differences, environmental factors and more frequent multi-parity amongst Saudi women.

# Carvedilol reduces decompensation and mortality in cirrhosis

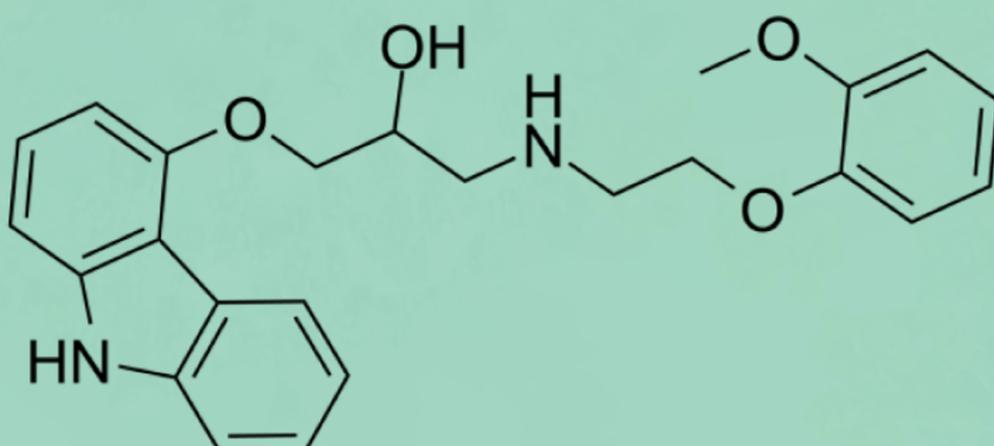
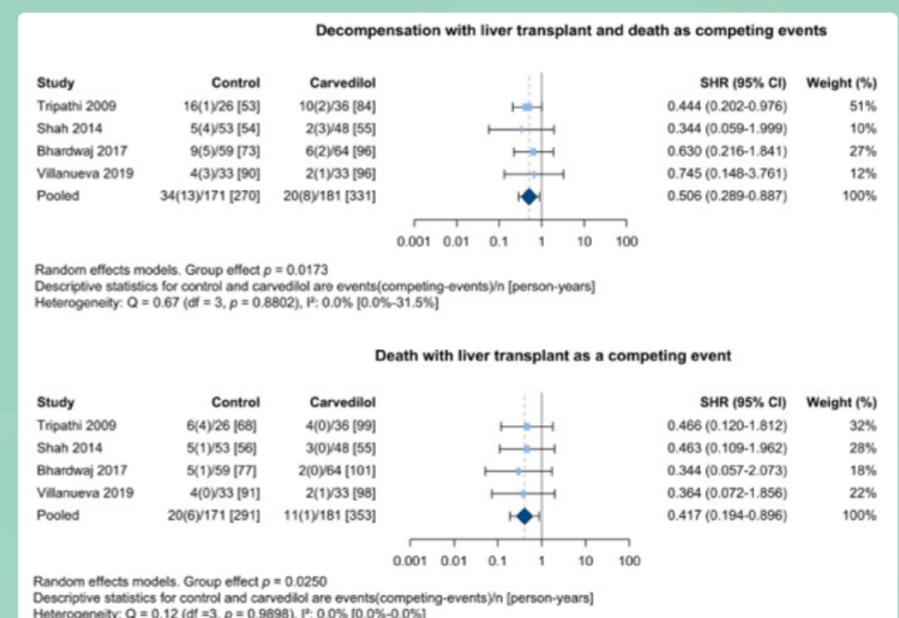
Villanueva C, et al. *J Hepatol.* 2022;77(4):1014-1025. doi: 10.1016/j.jhep.2022.05.021.

Carvedilol is a non-selective  $\beta$ -blocker that has been evaluated in prophylaxis against variceal upper gastrointestinal bleeding. Villanueva and colleagues evaluated the effect of this drug on the incidence of hepatic decompensation and mortality in patients with compensated cirrhosis. This meta-analysis included 4 randomized-controlled trials (RCT) with a total of 352 patients and compared those who received carvedilol (n=181 patients) to control (n=171 patients) that included patients who received esophageal variceal band ligation (n=79) and placebo (n=92).

Authors performed a competing-risk time-to-event meta-analysis using individual patient data obtained from principle investigators of RCTs. They included compensated patients only and the primary outcomes were prevention of decompensation and death. To improve sample homogeneity, propensity score for baseline covariates was performed.

The risk of developing decompensation was lower in carvedilol group compared to control, with hazard ratio of 0.506 (95% CI 0.289-0.887,  $p=0.017$ ), indicating that the risk of decompensation was reduced by almost 50% with the use of carvedilol. Similarly, the risk of death was also reduced by 58% with carvedilol (HR 0.417, 95% CI 0.194-0.896,  $p=0.025$ ).

These results need to be confirmed through a well-conducted large RCT. The statistical significance of the difference between groups is challenged by the wide confidence interval and the relatively small sample size, although a type II error is more likely in this scenario. The large difference in number of events seen in this meta-analysis may encourage physicians to use carvedilol more liberally in patients with compensated cirrhosis and portal hypertension with or without band ligation. We obviously need more evidence to know if this is a class effect or related to carvedilol only, and additionally if it can be used in patients with mild to moderate decompensation.



Dr. Ali H. Albenmoussa

# THE Excellence Corner

Interview with

## Prof. Hamad Al-Ashgar

**Editor:** Can you describe the challenges that you faced in your journey?

**Prof. Hamad Al-Ashgar:** My life's journey began in a small, agricultural village in Al-Qassim Province in Central Saudi Arabia, where life was quiet and unentertaining. The essence of life was practically devoid of basic amenities that we are so used to in today's living, such as an unhindered access to telephones or TVs, where in reality even access to a radio was a rare privilege. My subsequent transition to the bigger city of Buraidah, and from there on to the UK, was sudden and drastic, posing me with dual emotional and cultural shocks that took me quite a while to acclimatize and accommodate to. Back in the 1980s in UK, it was really difficult to secure a place in a medical college, where the challenge was to obtain high enough scores in Advanced Level qualifications in 3 subjects, as well as in English. Life was not easy, living with a British family, with their dogs and the presence of elderly couples. However, my struggles bore fruit when I did manage to get into medical school (Royal College of Surgeons in Ireland) in Dublin for a period lasting 6 years. I guess my interest in gastroenterology was sparked during medical school when I did two attachments, both in gastroenterology, thereby paving my intention from early on towards this field.

I returned to Saudi Arabia to do my internship, while hoping to attain another scholarship to travel abroad. To my bitter disappointment, all scholarships were stopped during the early 1990s. I then joined the Arab Board residency in Internal Medicine as most of us graduates did at that time, and then went shopping for board certification which I managed to collect with much fervor including the Arab, Jordanian, and Saudi Board in Internal Medicine, in addition to MRCP. I must confess that the early 1990s was a particularly difficult time for all of us, particularly those of us in the medical field. We lived in fear of war and as hospital staff, got training in



Al-Ashgar in 1986 at the graduation ceremony at RCSI in Dublin, Ireland

chemical warfare, which included things such as the wearing of the chemical protective masks and suits, which is now the stuff of Hollywood films. But for us back then, it was the reality.

I then enrolled in the gastroenterology fellowship program in King Faisal Specialist Hospital & Research Center (KFSH&RC), Riyadh and my dream of a lifetime became a reality. This was the only option of structured gastroenterology training at that time, and I had truly great mentors in the existing staff at that time, who gave me constant encouragement and support. I was then lucky to secure scholarship in Toronto, Canada to do advanced hepatology and liver transplant fellowship training, eventually returning back to Saudi Arabia in 1999 to be a consultant.

**Editor:** Can you list (what you believe are) your achievements in this field?

**Prof. Hamad Al-Ashgar:** After my return from Canada, my ambition was to establish a collaborative group to conduct research, eventually serving as the nidus for the establishment of SASLT. I am proud to have served in both SGA and SASLT as a board of director, as well Kabdek Association. My main task was to serve the community and I fulfilled this by being a member of Ministry of Health committees, by teaching and serving my patients and by leading in many of our hospital positions and committees.

I spent all my consulting life in KFSH&RC, with more than 10 years as Chairman of Department of Medicine. I take pride to have collaborated with my colleagues to establish many programs (like hepatitis, IBD, pulmonary hypertension, polycystic kidney, vascular access, thyroid tumor, thrombosis, and many other services like interventional endoscopy, hyperbaric oxygen, etc). All of these were done in a work/life balance that included clinical work, research, administration, care for my family and raising my children with my wife who provided me with the most supportive environment. I was also honored to have received the SASLT prize for excellence in 2019.

I have authored over 70 peer reviewed publications, including a book chapter, and presented many abstracts in both, national and international conferences. I have also been instrumental in formulation of national guidelines in the management of a few liver diseases. I have been fortunate to have received some awards, one from Toronto, Canada, and others from KFSH&RC, Riyadh, Saudi Arabia for research and administrative role recognition.



Dr. Al-Ashgar with other gastroenterology fellows (sitting) in a departmental gathering in 1995 at KFSH&RC

**Editor:** What changes would you advocate for the betterment of our goals in science?

**Prof. Hamad Al-Ashgar:** Saudi Arabia needs to be a leading nation when we chart the world map of science, and we can reach this goal by conducting research for the betterment of our community, and finding solutions that involve innovation and discovery. We can only achieve this by collaboration and good funding, with a clearly defined vision of what is truly needed.



With colleagues from across the country while attending an int'l conference in 2016

**Editor:** Any regrets or unfulfilled ambitions in life?

**Prof. Hamad Al-Ashgar:** I have no regrets at all. I believe I have attained many good things in work and personal life, having served as a physician for many years and having been witness to our country advance in many fields by leaps and bounds, especially in medicine, with the blocks of achievement turning into reality as in the Vision 2030.

**Editor:** What message would you like to pass on to this generation of doctors and the next?

**Prof. Hamad Al-Ashgar:** My strongest message to the next generations of doctors is to carry the task of being a doctor by having balance between life and work, family and personal well-being. After all, your personal well-being is the foundation for everything else that comes with it.



**Dr. Faisal M. Sanai**





Every year the Saudi Society for the Study of Liver Disease and Transplantation gives an excellence award to a deserving accomplished senior hepatologist or liver transplant surgeon honoring his outstanding contribution and distinguished work in the field of liver disease and transplantation.

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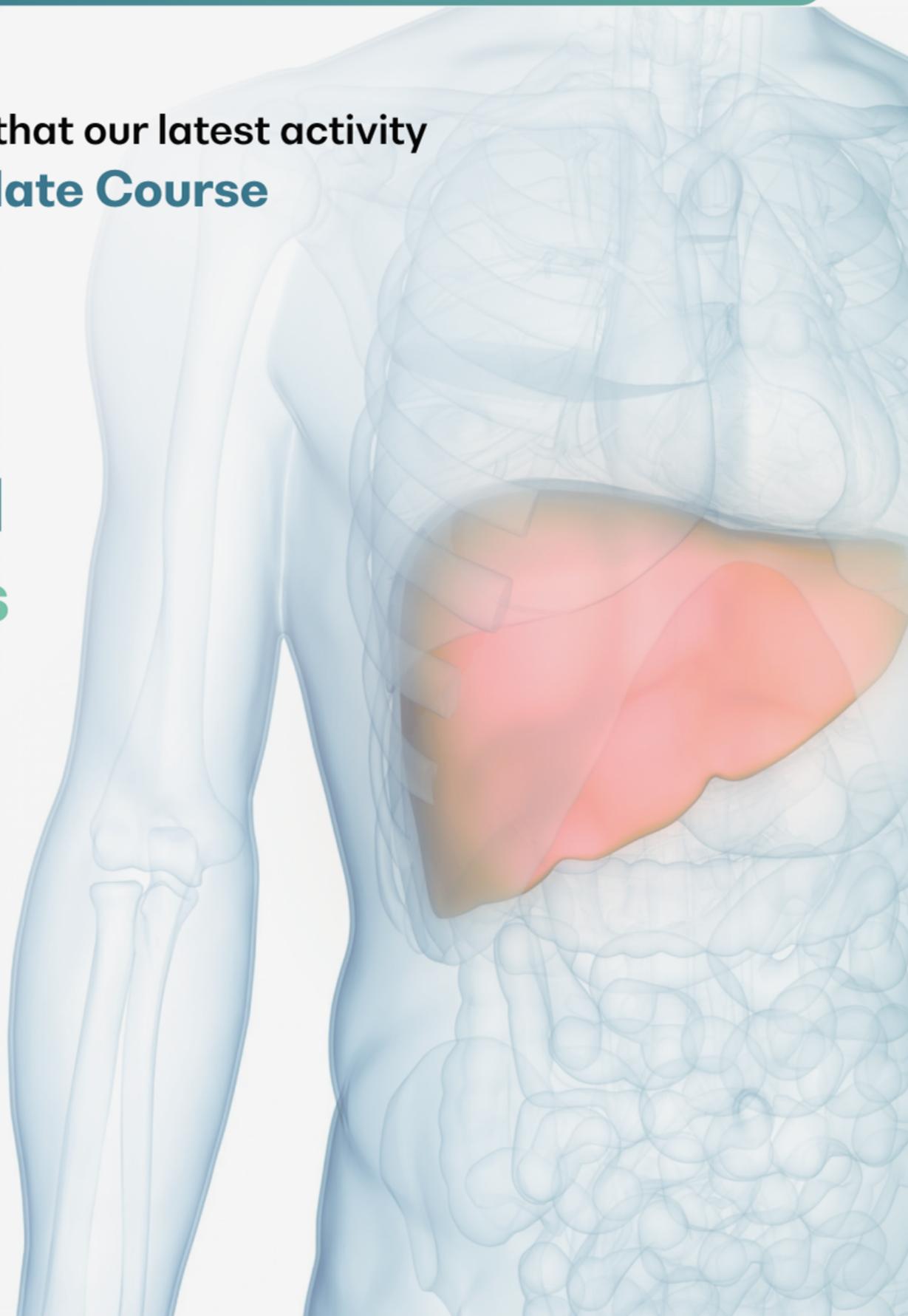
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**RACING 2030 HCV ELIMINATION VISION**

Dear Doctor,  
The Saudi Society of Studying the Liver Disease & Transplantation cordially invites you to attend it's conference  
"Racing the 2030 HCV Elimination Vision"

**SASLT**  
الجمعية السعودية لدراسة أمراض الكبد و زرع الكبد  
Saudi Society for the Study of Liver Disease and Transplantation

**Intercontinental Hotel /Hybrid**

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**CME Hours**

**Saturday 17<sup>th</sup> of September 2022**

**1:00 PM to 6:00 PM**



**RACING 2030 HCV ELIMINATION VISION**

Dear Doctor,  
The Saudi Society of Studying the Liver Disease & Transplantation cordially invites you to attend it's conference  
"Racing the 2030 HCV Elimination Vision"

**SASLT**  
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