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Official Organ of the European Society of Gastrointestinal Endoscopy (ESGE) and Affiliated Societies



**Advancing endoscopy
Forging connections**

A HYBRID EVENT

Convention Centre Dublin
Ireland, April 20 - 22, 2023



ESGE Days 2023

Abstract issue

 **Thieme**

ESGE Days 2023



Date/Venue:

20.–22. April 2023, Dublin, Ireland

Welcome message

Dear colleagues in endoscopy,

It is my honour to welcome you to the ESGE Days 2023 abstract supplement and invite you to browse the exciting research and developments in endoscopy that we are proud to present.

I am thrilled that we received 1,289 abstract submissions from 55 countries this year, breaking all previous submission records. After the success of ESGE Days last year in Prague there has been a sense of excitement in all our planning for Dublin, and we feel that this response confirmed to us that the 'Days' is an established global platform to share the best endoscopy research in Europe and beyond! A heartfelt THANK YOU to everyone who submitted. It is showcasing your research and clinical practice that is at the heart of our meeting and we remain indebted to you sharing your science with the ESGE Days community.

For ESGE Days 2023, we have encouraged the submissions of case reports and will be highlighting the best of these onsite in Dublin. These everyday practical scenarios complement the research provided by larger studies.

This year we will also be featuring Poster Tours in Dublin. In addition to those abstracts selected for oral presentations, the Poster Tours give exposure to additional abstracts of interest and an opportunity to engage with the authors in person.

'Behind the scenes' of this publication is a dedicated team. I am grateful to the Scientific Committee, whose work on the abstract review process, as well as the creation of the scientific programme is no easy feat! As we experience public sector strikes, the energy crisis, and ever-increasing strains on healthcare providers across Europe and beyond, for these physicians to continue to dedicate their precious time to further the field of endoscopy is deserving of gratitude from all of us.

At ESGE Days our mission is to advance endoscopy and forge connections, so I look forward to embracing the famous spirit of Irish hospitality and meeting you in person in Dublin to collaborate, network, and work towards a bright future for the field we share a passion for!

Your ESGE Scientific Committee Chair,
Marianna Arvanitakis



Marianna Arvanitakis
ESGE Scientific Committee Chair

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Age in years (mean ± SD)	67.73±15.86
Female Gender, n (%)	85 (54.8%)
Comorbidities, n (%)	
Hypertension	64 (41.2%)
Diabetes Mellitus	27 (17.4%)
Obesity	2 (1.2%)
Acute biliary pancreatitis	11 (7.1%)
Confirmed choledocholithiasis	50 (32.2%)
Imaging, n (%)	
US	130 (83.8%)
CT	58 (37.4%)
MRI	4 (2.5%)
EUS	65 (41.9%)
ERCP	48 (30.9%)
Dilated CBD on US	49 (31.6%)
CBD stone/sludge on US	47 (30.3%)

▶ Table 1

eP211 Underwater technique in complicated diverticular disease: initial experience

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Aims the underwater technique (UWT) has so far been used for the resection of sessile polyps, with satisfactory results in terms of efficacy and complications. The aim of this work is to demonstrate the effectiveness of the underwater technique for diagnostic purposes, in patients suffering from diverticular disease with insurmountable stenosis at traditional colonoscopy

Methods A cohort of 50 patients (20 D and 30 U – mean age 72 years) with incomplete colonic due to stenosing diverticular disease (DICA 4) confirmed by CT colon examination was enrolled. virtual colonoscopy performed as a diagnostic completion. All the patients had been evaluated at other endoscopy clinics and subsequently studied at the Endoscopy Center of the Benevento ASL, for the detection, in at least 15 patients, of lesions compatible with polyps > 6 mm on the colon CT scan. All patients underwent colonoscopy under conscious sedation with a thin colonoscope (Olympus PTH PF 190), filling the stenotic lumen with UWT [1–3].

Results In 41 patients, the use of the UW technique allowed the stenotic section to be overcome, allowing the examination to be completed; in the remaining 9 the stenosis was insurmountable. In the 15 patients with lesions compatible with polyps > 6 mm on colon CT, only 5 were positive, 2 of which with the finding of polypoid formations > 1 cm in sections other than those reported on colon CT. No complications were recorded both in the diagnostic phase and in the operative phase.

Conclusions The UW technique can represent an alternative method in the diagnosis of certain pathological and inflammatory conditions with a high risk of perforation.

Conflicts of interest Authors do not have any conflict of interest to disclose.

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eP212 Difficult cannulation criteria for ERCP procedures with or without trainee involvement

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Aims The criteria for difficult cannulation were proposed by the European Society of Gastrointestinal Endoscopy to define difficult biliary cannulation. Our study aimed to show correlation between time for cannulation and adverse events in trainee-involved procedures.

Methods For study were selected cases with biliary cannulation with or without trainee involvement. Assessment outcomes studied for cannulation time, attempts, inadvertent pancreatic duct (PD) cannulation, adverse events rates. All statistical analyses were performed using SPSS V27.0 software, P<0,05 was considered statistically significant.

Results We studied 586 cases with native papilla selected for ERCP (eligible for trainee-involved procedures) divided into two groups. Group 1 – trainee-procedure (293; age – 52.68 ± 8.6), Group 2 – non-trainee-procedures (293; age – 51.48 ± 9.5). Main part of these with biliary cannulation for biliary stones extraction (75%). According to study trainee-involved procedures had longer cannulation time (8.4 [3.1–18.8] vs. 2.3 [0.8–5.4] minutes), and more attempts (6 [2–11] vs. 2 [1–4]). The numbers of attempts and needle-knife pre-cut were restricted by trainers in difficult cases. In Group 1 were higher rate of inadvertent PD cannulation and pancreatic stent placement vs. procedures without trainee involvement (P<0.05). Incidences of post-ERCP pancreatitis following difficult cannulation were comparable [1–9].

Conclusions Performing cannulation trainee needs more time to choose right method and do it accurately. However, it has no correlation with rates of post-ERCP pancreatitis. The criteria for difficult cannulation could be changed in trainee-involved procedures.

Conflicts of interest Authors do not have any conflict of interest to disclose.

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eP213 High-risk polyps at screening colonoscopy are associated with upper gastrointestinal cancer mortality

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Aims Currently, gastric cancer screening is only cost-effective in countries with high incidence. Colorectal cancer screening is an effective method for the reduction of CRC incidence and receives high attendance rates. Integrated screening, where gastroscopy is performed in conjunction with colonoscopy, could help reduce the gastric cancer screening procedure burden in countries with low or intermediate incidence. However, there is a lack of population-based studies providing data on groups at high risk for mortality from gastric malignancies that might benefit from this approach.

Methods We used Cox proportional hazards model to identify an association of high-risk and low-risk finding (polyps \geq 10mm or with high-grade dysplasia vs <10 mm and no high-grade dysplasia or advanced adenoma vs non-advanced adenoma) with time to death from upper gastrointestinal (esophageal and gastric) cancer using Cox Proportional Hazards model.

Results In participants with non-advanced adenomas, hazards for upper GI cancer death were similar compared to participants with advanced adenomas (HR 1.37, 95% CI 1.01-1.72 and HR 1.35, 95% CI 0.94-1.95). However, in participants with polyps \geq 10 mm or HGD, hazards for upper GI cancer death were higher (HR 1.70, 95% CI 1.07-1.66).

Conclusions CRC screening participants with polyps <10 mm and no HGD have a lower risk for mortality from upper gastrointestinal cancers compared to participants with polyps >10 mm and HGD. Future studies will demonstrate whether integrated screening with additional gastroscopy is effective in CRC screening participants with large or highly dysplastic polyps.

Conflicts of interest Authors do not have any conflict of interest to disclose.

eP214 Feasibility, safety and efficacy of partially covered self-expandable metal stents for leaks after esophageal or gastric resection for malignancies: a single center experience

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Aims to assess the feasibility, safety and efficacy of partially covered self-expandable metal stents (PC SEMS) for leaks after esophageal or gastric resection for malignancies

Methods we retrospectively collected data of patients from November 2018 to October 2022

Results 23 patients (18 M, median age 70 yrs) were included. 11 patients had an esophagogastric anastomosis, 11 an esophagojejunal anastomosis and 1 an esophago-colonic anastomosis. 22 defects were anastomotic leak, 1 was a leak of the jejunal cul-de-sac. The median time between surgery and leak diagnosis was 8 (3-44) days. 20 (87 %) patients received Boston Ultraflex partially covered stent (100/120/150 mmx18/23 mm) and 3 (13 %) patients Boston Agile par-

tially covered stent (120/150x23 mm). Stent placement was technically successful in all patients. The median time between stent placement and removal was 29 (4-52) days. One patient died for other causes with stent in place. PC SEMS retrieval was safe and easy, except for one patient who needed stent-in-stent technique for the subsequent successful removal. 15/22 and 2/22 patients obtained leak resolution after one and two stent placement respectively, with an overall success rate of 77%. Concerning patients with persistent leak, 1 patient achieved defect healing with Esosponge, 4 (17%) patients needed re-intervention. During a median follow-up time of 4.4 (1.1-35.2) months, complications were observed in 4/22 (18%) patients: 2 migrations, 1 stricture at the level of the proximal stent margin, 1 self-limiting haemorrhage

Conclusions PC SEMS placement is a feasible, safe and effective technique for leak treatment after esophageal or gastric surgery for malignancies

Conflicts of interest Authors do not have any conflict of interest to disclose.

eP215 "Modified-Endoshield": A negative pressure box with a ventilation system to improve the safety of pediatric endoscopy during the COVID-19 pandemic

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Aims To increase the safety of endoscopy in the era of the COVID-19 pandemic, we described a negative airflow box with a leak-proof system.

Methods A transparent box was connected to a High Efficiency Particulate Air (HEPA) filter to create the negative pressure room and was placed over the patient's head and shoulders. A rubber glove was fastened to the endoscopic port to avoid aerosol leakage. For a 90-second interval, incense sticks were used to create fine particulate matter (PM), which was intended to resemble virus particles. The front and right sides and inside of the box were chosen as the locations for the PM 2.5 sensors. As control and test circumstances, respectively, the effectiveness of the negative pressure and leak-proof systems was qualified with and without negative pressure.

Results In control conditions, PM 2.5 gradually grew at the front side (493.2 + 208.9 mcg/m³), moved to the right side (185.1 + 118.4 mcg/m³), and then within the box (296.9 + 266.6 mcg/m³), reaching a stable state at the front side by 600 mcg/m³ in 11 seconds. While in test condition, PM 2.5 was rapidly moved to the inside (544.7 + 164.1 mcg/m³; p < 0.001) and reached a steady state in 10 seconds, with only a small number of particles detected outside (22.1 + 1.4 mcg/m³; p < 0.001 and 18.3 + 0.7 mcg/m³; p < 0.001 at the front and right side, respectively) (► **Table 1**).

Conclusions The negative pressure and glove leak proof had an efficacy to reduce aerosol transmission.

Conflicts of interest Authors do not have any conflict of interest to disclose.

PM 2.5 (mcg/m ³) / Conditions	Control	Test	p-value
Front	493.2 ± 208.9	22.1±1.4	< 0.001
Right	185.1 ± 118.4	18.3±0.7	< 0.001
Inside	296.9 ± 266.6	544.7±164.1	< 0.001

► **Table 1**