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Conclusions In our cohort, early recurrence following pEMR of 10-20mm nonpedunculated polyps was observed in 20% of cases. Ulceration within the polyp, fibrosis, higher SMSA score , deficient bowel preparation and incomplete resection were associated with higher recurrence rates, with incomplete resection emerging as an independent predictor. Clinicians should consider these factors when making post-pEMR management decisions for patients with 10-20mm nonpedunculated polyps. Further studies are needed to evaluate the impact on colorectal cancer (CCR) risk and CRC-related mortality in such cases.

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

eP532 Buried Bumper Syndrome: One size does not fit all

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Abstract Text A 94-year-old woman with post-stroke dysphagia underwent percutaneous endoscopic gastrostomy (PEG) placement. Four weeks later, she was readmitted due to peristomal leakage and phlegmon. CT scan excluded complications. Broad-spectrum antibiotics were initiated. EGD revealed internal bumper migration to the gastric wall and mucosal overgrowth. Reposition and tube replacement attempts failed. Then, an ERCP guidewire was introduced into the gastric lumen. Through the guidewire, the internal stoma was dilated using 7mm-9mm Savary-Gilliard dilators (SGD), followed by placement of a 24Fr PEG. Reintroduction of nutrition was uneventful.

Buried Bumper Syndrome (BBS) management depends on the time elapsed since the PEG placement and concomitant complications. Endoscopic dilation with SGD is a safe and effective procedure in selected cases of BBS with mucosal overgrowth of the PEG insertion site.

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

eP533 Underwater colonoscopy with endoscopic mucosal resection in cecum

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Aims Underwater endoscopic mucosal resection (UEMR) is a technique for the removal of colorectal nonpedunculated lesions. The our study aim is to compare the efficacy and safety of UEMR versus conventional endoscopic mucosal resection in patients with cecal lesions.

Methods The study included 68 patients with nonpedunculated cecal lesions with a diameter <20mm, 20-30mm, type 0-Is, 0-IIa or 0-IIa+Is according to the Paris Classification. Enrolled cases were divided into two groups: Group I comprised 36(52,9%) cases with underwater endoscopic mucosal resection and Group II 32(47,1%) patients with conventional endoscopic mucosal resection. Cases with deep submucosal invasion were not included. Optical evaluation with chromoscopy and NBI was performed by expert endoscopist, followed by endoscopic resection. The outcome was the lesion recurrence rate, en bloc resection, R0 resection rates, adverse events. Data were analysed using Chi-sq, descriptive statistic by SPSS version 26.0.

Results Underwater endoscopic mucosal resection was faster and easier to perform than conventional endoscopic mucosal resection. There were no differences in the overall recurrence rate between groups. However, the recurrence rate was lower for I Group (UEMR) (2,9%) in cases of 20-30mm lesions size (II Group – 8,8%); the R0 resection and adverse events showed the same tendency, only for polyps between 20 and 30 mm.

Conclusions Underwater endoscopic mucosal resection is safety method and could be considered for treatment of lesions between 20 and 30 mm in the cecal and right colon with low adverse events rates. [1–6]

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

References

[1] Pimentel-Nunes P, Dinis-Ribeiro M, Ponchon T et al. Endoscopic sub- mucosal dissection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline. Endoscopy 2015; 47: 829–54

[2] Bourke MJ, Bhandari P. How I remove polyps larger than 20 mm. Endoscopy 2019; 51: 1151–4

[3] Hamerski C, Samarasena J, Lee DP et al. 125 Underwater versus con- ventional endoscopic mucosal resection for the treatment of colorectal laterally spreading tumors: results from an international, multicenter, randomized controlled trial. Am J Gastroenterol 2019; 114: S75

[4] Chandan S, Khan SR, Kumar A et al. Efficacy and histologic accuracy of underwater versus conventional endoscopic mucosal resection for large (>20 mm) colorectal polyps: a comparative review and meta- analysis. Gastrointest Endosc 2021; 94: 471–82.e9

[5] Li DF, Lai MG, Yang MF et al. The efficacy and safety of underwater endoscopic mucosal resection for 10-mm colorectal polyps: systematic review and meta-analysis. Endoscopy 2021; 53: 636–46

[6] Rodríguez Sánchez J, Alvarez-Gonzalez MA, Pellisé M et al. Underwater versus conventional EMR of large nonpedunculated colorectal lesions: a multicenter randomized controlled trial. Gastrointest Endosc 2023; Volume 97 (No. 5): 941–51.e2

eP534 Endoscopic therapy of severe delayed-onset bleeding after transrectal prostate biopsy

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Abstract Text A 62-year-old man with a high prostate-specific antigen level underwent transrectal prostate biopsy. Seven days after, he was admitted for hematochezia and hemorrhagic shock. Prompt resuscitation was initiated. Digital compression was ineffective. An emergency colonoscopy was performed, revealing a recent clot in the inferior rectum, which, upon removal, exposed an elevation of the mucosa with a pulsatile, large-caliber vessel in the anterior wall just above the pectineal line, suggestive of a Dieulafoy's-like lesion, which initiated active bleeding during the procedure. Hemostasis was successfully achieved using three through-the-scope (TTS) clips. The patient had no further bleeding and no need for additional red blood cell transfusions.

Delayed and severe bleeding post-transrectal prostate biopsy occurs in 1% of cases. The application of TTS clips proved to be a secure, effective, and minimally invasive treatment.

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

eP535V Combined percutaneous-endoscopic post-hepatectomy bile-duct reconnection using a biloma as a meeting point

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Abstract Text Introduction: Interventional reconnection of severe bile-duct injury may avoid complex surgical revisions.

Case: High-output bile leakage after left hepatectomy followed by percutaneous drainage of biloma. EUS-guided transgastric biloma drainage with LAMS and fully covered metal stent at 1st endoscopic session. At revision ERCP, complete disconnection is confirmed. PTC is performed for rendezvous before 3rd session. A cholangioscope is passed into the biloma, and guidewires passed through the percutaneous catheters (biloma and segment VI) are retrieved. An Amsterdam 8.5F stent is placed across the biloma into segment VI. Pigtail stents placed though LAMS. Output stops.

Comment: Synergistic use of PTBD, EUS and ERCP with cholangioscopy reconnected the duct.