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Abstract issue

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eP062 Band-assisted EMR as the method of choice in the treatment of duodenal NET

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Aims Neuroendocrine neoplasms of the duodenum are submucosal, often small (up to 10 mm) neoplasms that require correct tactics for endoscopic removal. Therefore, our main aim was to define this tactic.

Methods Analysis of all available recommendations for the treatment of duodenal NET:1) ENETS Consensus Guidelines Update for Gastroduodenal Neuroendocrine Neoplasms;2) Endoscopic submucosal dissection for superficial gastrointestinal lesions: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2022;3) NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) Neuroendocrine and Adrenal Tumors.

Results After studying all available recommendations, we did not get a clear answer on the correct choice of D-NET removal method. The study included 11 patients who had D-NET of the supraampullary part of the duodenum with a size of 6 to 12 mm. All patients underwent band-assisted EMR. First of all, an indigo carmine solution was injected under the formation. neoplasms. The next stage was the imposition of a latex ligature on the formation according to the standard method. After that, EMR was performed with an endoscopic loop in Gastro-coag mode (BOWA-400). At the place of removal, the muscle layer is clearly visualized, without signs of damage to the latter. The defect is closed with an endoscopic clip. Histological examination confirms the completeness of the resection.

Conclusions Endoscopic band-assisted EMR is the method of choice for the removal of small duodenal NETs. Since interventions on the duodenum have a high risk of complications, this method is safe and effective, ensuring the completeness of the resection. ESD is economically impractical and technically more difficult with a higher risk of complications. [1–3]

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

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eP063 Isoperistaltic ileocolonic Anastomosis after Ileocecal Resection Reduces Colonoscopic Anastomosis-to-Small-Bowel Time

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Aims Side-to-side antiperistaltic ileo-colonic anastomosis (APICA) is widely used technique in Crohn’s disease (CD) patients. Its configuration makes the neo-terminal ileum intubation difficult, and might reduce rates of appropriate scoping, as required for assessment of disease relapse. The isoperistaltic ileo-colonic anastomosis (IPICA) may improve post-surgical endoscopic follow up of CD patients.

Our aim was to compare safety, efficacy, recurrence rates and feasibility of ileo-colonoscopy (IC) between the two anastomotic configurations.

Methods Data on all consecutive CD patients aged ≥ 18 years at a single tertiary center, who underwent ileo-colonic resection from 1/4/10 to 31/3/22,

were collected retrospectively. Patients with anastomotic types other than APICA and IPICA and lack of IC within 18 months from surgery, were excluded.

Results A total of 143 patients were included [82 males (57.3%), age 38.2 ± 14.3 years, disease duration 10.1 ± 9.5 years]. Twenty-six patients (18.5%) underwent IPICA and 117 patients (81.8%) APICA surgery. Patients did not differ in age, gender, BMI, smoking status, biologic treatment exposure and disease duration at time of surgery ($p = NS$). Duration of surgery was significantly longer for IPICA than APICA (295.4 ± 70.2 min vs 249.3 ± 60.6 min, $p < 0.001$, respectively). Rates of laparoscopic, lap-to-open and open procedures differed (57.7%, 30.8% and 11.5% for IPICA vs. 40.2%, 13.7% and 46.2%, for APICA, respectively; $p = 0.003$). Hospitalisation duration and post-surgical complications (Clavien-Dindo classification) were comparable ($p = NS$). Fifteen patients were re-admitted with post-surgical complications within 90 days (1/26 (3.8%) in IPICA vs 14/117 (12.0%) in APICA group, $p = 0.124$). At post-surgical IC, clinically significant anastomotic disease recurrence (Rutgeerts score $\geq 2b$) was observed in 38.5% of IPICA vs 34.2% of APICA, ($p = 0.820$). Excluding patients with stricture at anastomosis ($R_i = 4s$), no failure of small bowel (SB) intubation was observed in IPICA vs 11 patients (10.5%) in APICA group, yet statistical significance was not met ($p = 0.216$). SB intubation time (defined as time from first image of anastomosis to first image of SB) was significantly shorter for IPICA (1.2 ± 0.9 min) vs APICA (3.0 ± 3.0 min, $p < 0.001$).

Conclusions IPICA and APICA are comparable in procedural safety, anastomotic disease recurrence and rate of re-admissions. IPICA necessitates longer surgery time yet allows for significantly easier SB intubation with no intubation failure.

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

eP064 Trans-nasal endoscopy – A viable post pandemic recovery option?

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Aims There have been increasing demands on endoscopy services across the UK over recent years, heightened significantly by the COVID-19 pandemic. Whilst oesophagogastroduodenoscopy (OGD), is the standard upper gastrointestinal (UGI) investigational tool, it has recognised shortfalls. Trans-nasal endoscopy (TNE) offers an established alternative. It has been shown to be better tolerated, less aerosol generating, have fewer complications and possesses the flexibility to be utilised outside of the traditional endoscopy setting with fewer staff. This comparative study investigates differences in qualitative and quantitative outcomes in un-sedated OGD (uOGD) and TNE (uTNE).

Methods 144 participants were selected via non-random convenience sampling. 72 patients underwent uOGD and uTNE respectively. Modified questionnaires were used to collect participant responses to standardised questions across both cohorts. Patient demographic and procedure outcome data was retrieved from secure NHS databases. Non-parametric testing assessed statistically significant differences in participant survey responses.

Results Patient tolerability and overall satisfaction was significantly higher in uTNE ($P < 0.0001$, $P < 0.0001$) with a 48.7% increase in positive procedure tolerability ($P < 0.0001$) and a 44.1% decrease in poor patient experience ($P < 0.0001$) observed. uTNE procedures on average lasted 3 seconds longer while J-manoeuvre and D2 intubation rates were 1.4% lower in uTNE, all statistically insignificant ($P = 0.95$, $P > 0.99$, $P > 0.99$). All procedures had successful diagnoses with sufficient biopsy yields. uTNE patients spent 3.2 fewer days on the 2 week wait cancer pathway.

Conclusions uTNE was superior in patient tolerability, non-inferior in diagnostic capability, and its use led to shortened times on management pathways when compared to uOGD. These findings further support those from the existing TNE literature and allow us to consider TNE as an alternative to uOGD as we move forward in the national endoscopy service recovery post pandemic. Future studies may benefit from an expenditure-benefit analysis and investigate