

Conclusion 10% of patients with confirmed VTE had an endoscopy in the preceding 3 months of the diagnosis compared to 3% in the control group ($p < 0.001$). Pts undergoing endoscopy have a 3.6-fold increased risk of VTE compared to controls. Larger studies may highlight whether the type of endoscopic procedure or diagnosis may alter this risk.

Abstract PWE-209 Table 1

Analysis	Group	N	Endoscopy, N (%)	OR (95% CI)	p Value
All subjects	Controls	445	14 (3.2%)	3.58 (1.86 to 7.46)	<0.001
	Cases	445	45 (10.1%)		

Competing interests None declared.

REFERENCE

- Nice guidelines CG-92.

PWE-210 ENDOBRONCHIAL VIDEOSCOPE FOR TRANSESOPHAGEAL/TRANSGASTRIC EUS-FNA IN SPECIAL SITUATIONS: A NOVEL TOOL FOR THE GASTROINTESTINAL ENDOSONOGRAPHER

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Introduction Oesophageal strictures/narrowing pose a distinct challenge during linear pancreatico-biliary endoscopic ultrasound (EUS) examination as the linear echoendoscope has a relatively rigid tip, large diameter and is oblique viewing. Significant oesophageal narrowing may therefore preclude linear EUS guided fine needle aspiration (FNA). The ultrasonic endobronchial videoscope (EBUS) has a much thinner diameter but, is considerably shorter and does not have air insufflation. It may however be of use in scenarios when there is oesophageal narrowing.¹

Methods We report the retrospective assessment of our experience of using the EBUS scope to characterise and FNA pancreatic and mediastinal lesions that were unsuitable for EUS examination using the linear echoendoscope. Our unit performs in excess of 750 pancreaticobiliary EUS examination a year.

Results Patient 1: 76-year-old man presented with mass in body of pancreas. He had an oesophageal stricture which impeded passage of a linear echoendoscope (Pentax EG-3870UTK). The Pentax endobronchial videoscope EB-1970OUK (EBUS) was used, which passed the stricture easily. EUS demonstrated multiple hypoechoic lesions. Tissue elastography revealed a blue predominant pattern with elevated strain ratio suggesting malignancy. FNA confirmed metastatic renal cell carcinoma. Patient 2: 63-yr-old female presented with progressive dyspnoea, dysphagia and stridor. CT showed massive mediastinal lymphadenopathy compressing the airway (over 13 cm) and the oesophagus. The length of compression meant an airway stent was not feasible. EUS-FNA was requested to obtain tissue to assess suitability for chemo-radiotherapy. The linear echoendoscope would not pass. EBUS scope documented massive mediastinal lymphadenopathy. FNA confirmed high grade neuroendocrine/small cell carcinoma. Patient 3: A 72-year-old gentleman presented with inoperable pancreatic malignancy based on CT scan abdomen. EUS-FNA was requested prior to initiation of chemotherapy. The linear echoendoscope would not pass the narrowed gastro-oesophageal junction probably secondary to achalasia. The EBUS scope was negotiated. There was a 27 mm mass in the body of pancreas extending posteriorly and involving the portal vein confluence. FNA was successfully obtained.

Conclusion We report the successful usage of EBUS scope to examine abnormalities inaccessible to the standard linear echoendoscope.

This work stresses the need to adopt new technologies to enhance the available diagnostic strategies for our patients.

Competing interests None declared.

REFERENCE

- Buxbaum JL, Eloubeidi MA. Transgastric endoscopic ultrasound guided fine needle aspiration in patients with esophageal narrowing using the ultrasonic bronchovideoscope. *Dis Esophagus* 2011;**24**:458–61.

PWE-211 LONGITUDINAL SURVEILLANCE OF SUBMUCOSAL TUMOURS BY ENDOSCOPIC ULTRASOUND: A SINGLE OPERATOR EXPERIENCE

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Introduction Endoscopic ultrasound (EUS) provides increasingly improved assessment of submucosal tumours (SMT). The low yield of fine needle aspiration and the benign nature of the majority of lesions leave the optimal management for smaller, asymptomatic lesions unclear as further invasive procedures or surgery may be avoidable. Longitudinal studies characterising interval change of SMT are lacking and may provide information useful in optimising management. We report the experience of a single operator in the EUS surveillance of SMTs.

Methods Patient cases were reviewed at two tertiary referral hospitals and one private hospital for patients who had serial EUS of the same lesion. EUS was performed by a single operator (RYC). For patients who had more than two EUS studies, details of the first and last were examined. Site, maximal diameter and layer of involvement were recorded. Paired data were analysed using a paired t-test with tests for correlation.

Results 73 patients with SMT had at least two EUS procedures between February 2002 and October 2011. Lesions were found in the oesophagus (14), stomach (51) and duodenum (8) with involvement of the submucosa (40), deep submucosa/muscularis propria (4) and muscularis propria (29). The range between first and last EUS was 4–80 months. The lesions varied between 4 and 50 mm with a mean maximal diameter of 15.13 mm (95% CI 12.78 to 17.49) for the first EUS and 15.73 mm (95% CI 13.36 to 18.09) for the second EUS. Paired t-test analysis between the first and last measurements show that there was no significant difference ($p = 0.2321$), with good correlation and effective pairing ($r = 0.9128$, $p < 0.0001$).

Conclusion In our study of submucosal tumours smaller than 50 mm, we showed no significant change in size on surveillance EUS. Further longitudinal studies are needed to determine optimal surveillance regimen for SMTs.

Competing interests None declared.

PWE-212 ACHIEVING DEFINITIVE HAEMOSTASIS IN NON-VARICEAL UPPER GASTROINTESTINAL BLEEDING—A SINGLE UK TERTIARY CENTRE EXPERIENCE

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Introduction Despite advances in endoscopic therapy for non-variceal upper gastrointestinal bleeding (NV-UGIB), achieving definitive haemostasis remains a challenge.¹ Radiological intervention with embolisation is an alternative to surgery where endoscopic