

need for dose escalation. It appears to be more effective, better tolerated and safer (less haematological disturbance) than FDA. These results will serve to allay the fear of toxicity of LDAA and question the need for thiopurine metabolite level profiling prior to using this apparently superior therapeutic approach.

**Disclosure of Interest** None Declared.

#### OC-007 HAEMOPOETIC STEM CELL TRANSPLANTATION FOR SEVERE RESISTANT CROHN'S DISEASE: PRELIMINARY EVIDENCE FOR DURABLE BENEFIT

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**Introduction** The Autologous Stem Cell Transplantation International Crohn's Disease (ASTIC) Trial shows haemopoietic stem cell transplantation (HSCT) to be effective over one year in Crohn's disease, but its durability remains to be established.

**Methods** ASTIC is a multicentre parallel group randomised controlled trial in patients with impaired quality of life due to Crohn's Disease that is resistant to established treatments. All patients undergo stem cell mobilisation before HSCT given immediately (one month: early HSCT) or after a delay of thirteen months (late HSCT). This abstract describes currently available data over 2 years and includes the first report of changes occurring in the first year transplantation in the late HSCT group.

**Results** A full analysis of progress over one year has shown a reduction in Crohn's Disease Activity Index (CDAI) from 326 (range 163–512) to 162 (12–506) and in the SES-CD endoscopic score from 13 (5–33) to 3 (0–200) in patients following early HSCT (n = 23) compared to 354 (91–581) to 298 (70–589, active vs control p = 0.01) and 13.5 (0–36) to 7 (1–27, active vs control p = 0.02) respectively in the control group prior to transplantation (n = 22). The Table shows data for those patients (approximately 50%) with full data currently available to two years (one year after transplantation in the control group).

Scores for the IBD-Q quality of life index improved from 123 (103–144) to 165 (125–206) following early HSCT and were maintained at 157 (126–213). Scores rose from 108 (79–136) to 147 (108–188) in the year following delayed HSCT.

**Conclusion** If full data (available June 2014) confirm these preliminary results, it would support the notion that improvements in CDAI, endoscopic appearances and quality of life benefit persist and may possibly increase over the second year following transplantation. One year data in the delayed group show a similar magnitude of effect to that seen in patients undergoing early transplantation.

**Disclosure of Interest** None Declared.

**Abstract OC-007 Table 1**

	CDAI (n = 12 and 14)		SES-CD (n = 13 and 13)		EQ5D VAS (n = 9 and 10)	
	Early HSCT	Late HSCT	Early HSCT	Late HSCT	Early HSCT	Late HSCT
Baseline	338 (264–473)	354 (264–473)	13 (8.5–25)	14 (4.5–19.5)	56 (39–65)	35 (29–60)
1 year	162 (73–280)*	288 (209–368)	3 (1.5–10)*	6 (3–20)	80 (68–88)*	50 (21–70)
2 year	90 (36–231)*	155 (84–300)*	3 (0–10.5)*	2 (0–6.5)*	87 (64–91)*	74 (43–83)*

Values shown are median and interquartile range.

Asterisked data\*: Post HSCT

## Endoscopy section free papers

### OC-008 ENDOSCOPIC SUBMUCOSAL DISSECTION CAN TRANSFORM THE MANAGEMENT OF PATIENTS WITH UPPER GASTROINTESTINAL SUBMUCOSAL TUMOURS: RESULTS FROM A UK SERIES

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**Introduction** It is very difficult to establish an accurate diagnosis for upper GI submucosal tumours. Biopsy during endoscopy cannot go deep enough. EUS is unable to give a tissue diagnosis. The risks of surgical resection are higher than the benefits as the lesion may very well be benign. As a result most of these patients keep having endoscopic surveillance as 'possible' GISTs.

**Methods** A retrospective cohort study of patients undergoing ESD for upper GI submucosal tumours. They were all referred to us as possible GISTs that were found to be growing in size on surveillance. ESD was carried out in all these cases. As these lesions are mostly bulky, gravity and patient positioning were utilised as traction during ESD to achieve deroofting and enucleation of these tumours. Any complications were recorded. Endoscopic follow up was performed to assess for incomplete resection or recurrence.

**Results** 21 submucosal lesions were resected by ESD between 2007 and 2013. 7 were oesophageal, 10 gastric and 4 duodenal. Sizes ranged from 10 to 35mm. Endoscopic clearance was achieved in all cases. Histology showed a wide range of diagnoses, mostly benign (table). There was 1 complication; a micro-perforation which was identified and clipped intraprocedurally, giving a complication rate of 4.7%. On follow up, there was 1 recurrence (recurrence rate 4.7%) which was managed

**Abstract OC-008 Table 1** Histological diagnosis of submucosal tumours resected by ESD

Diagnosis	Number
Granular cell tumour	3
GIST	2
Leiomyoma	2
Pancreatic acinar tissue	1
Carcinoid	6
Lipoma	2
Inflammatory fibroid polyp, hyperplastic polyp	1+1
Synovial sarcoma	1
Gangliocytic paraganglioma	1

endoscopically. 1 patient had surgery as the ESD specimen showed a synovial sarcoma. Endoscopic cure rate was 95.2%.

**Conclusion** ESD is a safe and novel, minimal access therapeutic technique which has the potential to transform management of submucosal tumours. Patients go from the uncertainty of having repeated endoscopies for an unknown diagnosis, to having it completely removed and cured in the vast majority, without the need for continuing endoscopies. In the remaining cases, ESD specimens provide an accurate histological diagnosis based on which definite management plans can be made.

**Disclosure of Interest** None Declared.

#### OC-009 A MULTICENTRE RETROSPECTIVE COMPARISON OF PLASTIC, UNCOVERED AND FULLY COVERED METAL STENTS IN THE MANAGEMENT OF DISTAL MALIGNANT BILIARY STRICTURES

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**Introduction** Uncovered self-expanding metal stents (USEMS) remain patent longer than plastic stents (PS) in patients with malignant bile duct strictures (MBDS). However, their difficult removal can compromise surgical tumour resection and so, prior to tumour staging a PS is commonly used. A solution may be offered by metal stents which have been coated with plastic, making them easier to remove. Our preliminary data analysis <sup>[1]</sup> suggested that fully covered self-expanding metal stents (FCSEMS) used as first line management of MBDS result in a longer patency time and similar complication rates compared to USEMS and PS. We now present data from an expanded database of patients to provide further evidence of the efficacy of FCSEMS in this situation.

**Methods** A multicentre retrospective study was conducted of patients with MBDS who underwent ERCP and primary stenting with PS, USEMS or FCSEMS between 2007 and 2013. Data was collected from patient records on age, cancer type, stent patency time, complications and survival. Patency time was calculated as the period between stent insertion and occlusion, death or resection with a patent stent. Patients who underwent resection were excluded from the patient survival analysis. Statistical analysis used Kaplan Meier and Log Rank tests for patency and survival and Fisher's exact test for complications. The software used was IBM SPSS Statistics 20.

**Results** 268 patients were included. FCSEMS (n = 41) remained patent for a mean of 292 days versus 150 days for USEMS (n = 89) (p < 0.001) and 68 days for PS (n = 138) (p < 0.001). FCSEMS also resulted in a statistically significant improvement in patient survival with a mean of 297 days versus 191 days for USEMS (p < 0.001) and 216 days for PS (p = 0.001). Both FCSEMS and USEMS produced a significantly lower incidence of cholangitis than PS (p < 0.047 and <0.013 respectively). There were 2 episodes of pancreatitis in the FCSEMS group (4.9%) compared to 3 in the PS group (2.2%) and 1 in the USEMS group (1.1%) but this was not statistically significant.

**Conclusion** For primary stenting of MBDS, FCSEMS result in a longer patency time and a reduced incidence of cholangitis compared to PS. Combined with evidence supporting their ease of operative removal, this data suggests FCSEMS may be the superior option for primary stenting of MBDS. However, a larger

cohort will be required to clarify the significance of the increased risk of pancreatitis observed in the FCSEMS group.

#### REFERENCE

- 1 Sampaziotis *et al.* A retrospective comparison of plastic, uncovered and fully covered metal stents in the management of distal malignant biliary strictures. *BSG Abstract* 13–1209

**Disclosure of Interest** None Declared.

#### OC-010 ENDOSCOPIC RESECTION OF DUODENAL ADENOMAS – COMPARISON OF SAFETY AND EFFICACY BETWEEN SPORADIC ADENOMAS AND ADENOMAS IN FAP

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**Introduction** Although there is a low risk of malignant conversion of duodenal polyps in FAP, EMR is often considered. However, few studies have looked at the safety and efficacy of EMR. We compared the outcome of duodenal EMR's in patients with FAP vs sporadic adenomas. To our knowledge, this is the largest series of duodenal EMRs that is published so far.<sup>1</sup>

**Methods** We looked at Clinical records of all patients who underwent endoscopic resections for duodenal adenomas at Leeds in a 10 year period.

**Results** A total of 49 sporadic adenomas were resected (in 51 patients) and 44 FAP related (in 22 patients). Most lesions appeared either sessile (43) or flat elevated (48). The average size of the FAP related polyps was 16.9 vs. 20.7 mm in sporadic lesions. Most were removed by standard EMR (n = 82) rather than the strip biopsy technique (n = 9). Two procedures failed and no follow-up data was available after the resection of 2 sporadic polyps.

The final histology of the lesions were; TA+LGD (76), TA+HGD (13), adenocarcinoma (2) and 2 polyps were not retrieved. In 11 lesions, there was a change in the histological grade after resection.

There were 4 perforations (4.3%), 3 were managed surgically. 12 patients (13%) were readmitted with significant late GI bleeding and 8 patients required endoscopic therapy and transfusion.

There was no significant difference in the success rates in the two groups (19/44 vs. 32/49) p value 0.94). However, the resection of polyps ≥ 2 cm were significantly more likely to be associated with a complication (7/59 vs. 8/19 p = 0.02). There was no difference in the risk of complications with the polyp location, ASA status, Spigelman score or patient age.

Amongst the FAP polyps, polyps >20 mm were significantly more likely to have local recurrence (3/6 vs 3/31 p value 0.04). There was no difference in the chances of success of the resection with the growth pattern, the location of the polyp or the Spigelman score.

**Conclusion** Duodenal EMR is hazardous, particularly when lesions 2 cm or larger are resected. However, there was no significant difference in the hazards or success rates between the two groups. Most FAP patients had further neoplasia on follow up, but this is due to the fact that many of the adenomas were not resected /treated in the first sitting.

#### REFERENCE

- 1 Basford P, Bhandari P. Endoscopic management of nonampullary duodenal polyps. *Therap Adv Gastroenterol.* 2012 March; 5(2):127–138

**Disclosure of Interest** None Declared.