Endoscopy symposium: how I do it - ERCP

OC-075  ANALYSIS OF LONG-TERM OUTCOMES AFTER ENDOSCOPIC RADIOFREQUENCY ABLATION FOR BILE DUCT STRICTURES IN PANCREATIC MALIGNANCY SUGGESTS POTENTIAL SURVIVAL BENEFIT
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1,2 D Westaby, 1Endoscopy, Royal London Hospital, Barts Health NHS Trust, 2HPB Unit, Imperial College Healthcare NHS Trust; 1Gastroenterology, Chelsea & Westminster NHS Foundation Trust, London, UK

Introduction Pancreatic carcinoma carries a poor prognosis with only 10–20% of patients amenable to attempts at curative surgery at presentation. Biliary obstruction is a common complication and many patients will require self-expanding metal stent (SEMS) insertion for definitive decompression. A recent pioneering phase I/II study in our tertiary referral centre demonstrated excellent safety and 90d stent patency with endobiliary radiofrequency ablation (RFA) as an adjunct to SEMS insertion. The longer-term impact of this novel endoscopic treatment modality on biliary drainage and patient survival in advanced pancreatic carcinoma is unknown.

Objective To investigate the longer-term efficacy of endobiliary RFA in the management of malignant bile duct obstruction associated with inoperable pancreatic carcinoma.

Methods Retrospective cohort analysis of 25 patients with unresectable pancreatic carcinoma undergoing RFA + SEMS insertion, and 46 matched controls undergoing SEMS insertion alone, for malignant biliary obstruction in a single tertiary referral centre. Patients were stringently matched for age, sex, metastases, ASA/ co-morbidities, and intention to treat with palliative chemotherapy. Survival, maintenance of stent patency, and procedure-related complications were assessed.

Results RFA and control groups were closely matched- age 68.9 +/- 9.0y vs. 68.9 +/- 9.9y, p = 0.791; ASA 2.35 +/- 0.65 vs. 2.54 +/- 0.50, p = 0.086; metastases at treatment 9/23 (39.1%) vs. 18/46 (39.1%), p = 0.800; chemotherapy 16/23 (69.6%) vs. 24/46 (52.2%), p = 0.203. Median survival was 227d after RFA vs. 123.5d in controls (HR 0.633 CI 0.378–1.060, p = 0.011). RFA was independently predictive of survival at 90d (OR 16.14, CI 1.35–193.18, p = 0.028) and 180d (OR 4.25, CI 1.00–18.01, p = 0.049). Overall SEMS patency rates were the same across both groups, though more patients were alive with a patent index SEMS after RFA within the first few months (73.9% vs. 41.3% at 4.5m, p = 0.012). Complications of RFA were few (1 pancreatitis, 1 cholangitis), with a median post-procedure inpatient stay of 1d (1–8).

Conclusion In the single largest case series to date, endobiliary RFA was found to be a safe and efficacious adjunctive treatment in the management of patients with advanced pancreatic malignancy and biliary obstruction, and demonstrated potential early survival benefit. These data suggest that endobiliary RFA could be an additional treatment option in advanced pancreatic carcinoma, and form the basis from which future prospective clinical trials of this novel treatment modality can be designed.


OC-076  SYRINGE SIZE INFLUENCES THE AMOUNT OF MIDAZOLAM ADMINISTERED DURING SEATED ENDOSCOPY
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1 D Haldar, 1,2 M Quraishi, 1K Glover, 1S Keen, 1,3 A Farmer, 1Gastroenterology, Shrewsbury & Telford NHS Trust, Telford, UK

Introduction Sidestream sedation is a common practice by endoscopists in the UK but there is no evidence that one particular syringe size is superior to another for sedation. An audit of 300 sedations across a large NHS trust was performed to examine the syringe size delivered. The effect of syringe size on the amount of midazolam administered was also assessed.

Methods The audit was performed over 2 years (1/11–12/12) and 500 patients undergoing non-Upper GI endoscopy under sedation were included. Sedation was delivered by endoscopists and nurses using 5, 10, and 20mL syringes. A total of 20 patients with repeat endoscopy were included. Data collected was time of the procedure, sedative agent and dose administered, patient data, and complications. Dosage of midazolam was converted to dose per kilogram of body weight.

Results 300 patients (215 male, 85 female; mean age 58.1 years) were included. Midazolam was used as a sedative agent in 98% of cases. The mean sedation time was 11.5 minutes. Of whom 145 patients used 5mL syringes (48%), 115 patients used 10mL syringes (38%), and 40 patients used 20mL syringes (14%). The median dose of midazolam was 0.05mg/kg (IQR 0.03–0.08mg/kg).

Conclusion The large variation in syringe size used and the ability to calculate the correct midazolam dosage per kilogram of body weight, highlights the need for standardisation of syringe size used in sedation administration. There was no significant difference in the amount of midazolam administered when comparing the 5mL, 10mL and 20mL syringes (p = 0.12).

Disclosure of Interest None Declared.