Abstract PTU-018 Figure 1 Stomach specimen showing multiple nodular GISTs, involving the mucosa and serosa

Discussion The presence of multiple sporadic GISTs is extremely rare, with only one case-report in the literature. The patient had a reported normal paediatric development. She had no physical signs of NF-1 and there were no family history of GISTs.

It is certainly unclear if her multiple lesions were the result of metastatic spreading of a single primary GIST. Certainly further research is required to explore this phenomenon.

Despite a 'tunnelled' approach to biopsying the GIST, an OGD was not an effective way of achieving histological diagnosis, and highlighted the continuing importance of EUS and fine needle biopsy in the diagnostic investigations of upper GI lesions.

Surgery remains the cornerstone to treatment, despite the availability of targeted chemotherapy. Understandably, a subtotal gastrectomy for this young patient may have psychological and nutritional long-term sequelae.

REFERENCE

1. Graziosi L, et al. Unique case of sporadic multiple gastrointestinal stromal tumour. *Int J Surg Case Rep* 2015;**9**:98–100.

PTU-019 OUTCOMES FROM MESENTERIC ANGIOGRAPHY AND EMBOLISATION IN NON-VARICEAL UPPER GI BLEEDING; A SINGLE CENTRE EXPERIENCE

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Introduction Upper GI bleeding remains an important cause of morbidity and mortality. Mortality rates in non-variceal upper GI bleeding have remained relatively static over recent decades despite an ever-increasing range of therapeutic options.

Interventional radiology (IR) has become an increasingly available tool for management of upper GI bleeding when endoscopic haemostasis has failed. However, literature is lacking surrounding the technical success and long term outcomes of mesenteric embolisation in patients with non-variceal upper GI haemorrhage.

We therefore wished to assess the overall technical efficacy and outcomes of interventional radiology in patients presenting with upper GI haemorrhage who had undergone initial endoscopy at the Royal Infirmary of Edinburgh.

Methods We retrospectively analysed the interventional radiology database for all patients who had undergone embolisation procedures. We then focussed on patients who had presented with non-variceal haemorrhage and assessed their outcomes using computer-based records. Patients were followed up for a minimum of 1 year.

Results Data were available from 2007 onward. We assessed patient's mortality outcomes at 30 days and 1 year. In total, 24 patients had undergone mesenteric embolisation for non-variceal upper GI haemorrhage (15 female, 9 males). Median age was 72 (range 52–96).

Over half of patients (14 of 24, 58.3%) had an ASA grade of III or IV (figure 1).

19 of 24 had information available to calculate Glasgow-Blatchford score, with a median score of 15 (figure 2).

Mean length of hospital stay in survivors was 31.75 days (5–148).

23 lesions were located in the duodenum, 1 in the oesophagus. There were 2 Dieulafoy lesions, 1 tumour vessel, 1 unclear bleeding point and 20 ulcers with varying stigmata.

5 patients had already undergone surgical management of their bleeding lesion prior to IR.

IR was technically successful in 22 of 24 patients. 4 out of 24 patients rebled following embolisation.

No patients developed an acute kidney injury following angiography.

6 out of 24 (25%) of patients died within 30 days of their IR procedure (figure 3).

8 out of 24 (33%) died within 1 year. 3 of these were due to bleeding, 3 due to sepsis and 2 due to malignancies (figure 4).

Conclusions Mesenteric embolisation in patients with significant non-variceal upper GI bleeding has high technical success rates with low rebleeding rates, in a patient population that often is elderly with significant comorbidity.

Approximately one third of patients who undergo interventional radiology procedures for non-variceal upper GI haemorrhage will be dead at 1 year; the majority from non-bleeding related causes.

Abstract PTU-019 Figure 1 ASA Grade

Abstract PTU-019 Figure 2 Glasgow-Blatchford Score

Abstract PTU-019 Figure 3 Mortality at 30 days

Abstract PTU-019 Figure 4 Mortality at 1 year

PTU-020 INTRODUCTION OF SEMS FOR MALIGNANT DISTAL BILIARY STRICTURES AT A LARGE LONDON DISTRICT GENERAL HOSPITAL

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Introduction Biliary stents are commonly used to treat malignant biliary obstruction. Compared to plastic stents, self-expanding metal stents (SEMS) have a wider diameter and therefore offer enhanced biliary decompression and a longer duration of patency. In addition, biliary decompression with SEMS insertion at ERCP commands a significantly higher level of reimbursement than if a plastic stent is employed. For these reasons, at our hospital since 2015, plastic stents have been abandoned in favour of uncovered or covered SEMS (60 mm ×10 mm) in patients with unresectable disease or potentially resectable disease respectively. Herein, we report the first 2 years of this change in endoscopic practice at a large DGH in East London.

Methods Patients diagnosed with either pancreatic or biliary tract cancer between April 2015 and April 2017 and who underwent endoscopic biliary stenting were prospectively audited. Retrospective Data collection was performed from electronic systems including Somerset, CRS, EPR and unisoft GI reporting from this prospective cohort.

Results Of 86 patients diagnosed with pancreatic or bile duct cancer, 45 patients (52%) underwent biliary stenting (37 distal biliary stricture, 9 with a perihilar stricture). Of the 37 with a distal stricture, CBD cannulation rate was 92%, the remainder required a rendezvous procedure to access the CBD. A SEMS was deployed across the stricture in all cases. A fully covered and uncovered SEMS was deployed in 27 and 12 patient respectively. A >50% reduction in bilirubin was identified in 94% of cases with this effect similar in both covered and uncovered SEMS. Following SEMS insertion 77% of patients achieved a bilirubin <50 μmol/L. In total, 24 patients required repeat ERCP due to tumour progression with an average of 2.2 interventions per patient. During re-intervention, a new SEMS was deployed within the previous SEMS. 30 mortality post ERCP was 9%. Mortality at 6 months was 19%. Distal stent migration was not identified in any patient. Four patients (3 covered and 1 uncovered) suffered cholecystitis due to gallbladder contrast retention after occlusion of the cystic duct orifice. Whereas this was treated with stent removal in patients with covered SEMS, cholecystostomy drainage was required in the patient with uncovered SEMS.