(ESD) are available. Our aim was to assess the usefulness, effectiveness and safety of SITE-facilitated ESD for resection of a large rectal lesion.

Methods An 82-year-old woman with a history of ischaemic heart disease, hypertension, atrial fibrillation, type 2 diabetes mellitus and deep vein thrombosis, was referred to our centre for ESD of a 60 mm rectal mixed-nodular type laterally spreading tumour (LST-GM) (Paris 0-Is, Kudo pit pattern III/IV), 10 cm from the anal verge.

Results SITE-facilitated ESD was performed under conscious sedation using the pocket creation method (PCM). A gastro-scope with incorporated water-jet and NearFocus functions (GIF-H290, Olympus, Japan), short ST hood (Fujifilm, Japan) and a 2.5 mm FlushKnife (Fujifilm, Japan) were used. Carbon dioxide (CO₂) insufflation was used during the initial incision and submucosal trimming on the anal side of the lesion. The CO₂ insufflator was then turned off, gas was aspirated from the lumen and the lesion was submerged in physiological saline using the water-jet function. SITE-facilitated ESD was then performed using NearFocus mode. Saline-immersion eliminated any fluid-gas interfaces obviating the need for suction. The use of saline-immersion with NearFocus also facilitated more precise, minimal contact dissection and enhanced pre-emptive visualisation of submucosal vessels, for avoidance of intraprocedural bleeding. Once the submucosa was successfully dissected, the remaining lateral and oral incisions were completed successfully for en-bloc resection; histopathology confirmed R0 resection.

Conclusion SITE-facilitated ESD appears to be a useful, safe and effective technique. In our experience, it appears to confer several potential advantages which include: improved endoscopic visualisation (with augmented magnification), minimal contact dissection (likely due to the superior electrical conductivity of saline) and also reduced tissue friability (due to the isotonic nature of physiological saline vis-à-vis water-immersion).

REFERENCE

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ADTU-01 FIRST REPORT OF A SECONDARY AORTO-JEJUNAL FISTULA DIAGNOSED BY DOUBLE-BALLOON ENTEROSCOPY

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10.1136/gutjnl-2018-BSGAbstracts.99

Introduction Aorto-jejunal fistula (AJF) is a very rare, life threatening condition which may result in catastrophic gastrointestinal (GI) bleeding. Secondary AJF is usually associated with a history of previous surgical repair of an abdominal aortic aneurysm (AAA).

Methods An 86-year-old woman with intermittent severe obscure-overt GI bleeding (with negative upper and lower GI endoscopies) was transferred as a tertiary referral to our institution for further investigation and management. Small bowel capsule endoscopy (SBCE) had shown active bleeding within the proximal jejunum. The patient's history of AAA Dacron-graft repair 9 years previously, raised our suspicion of a possible aorto-enteric fistula (AEF).

Results Although cross-sectional imaging (CT) had demonstrated close proximity of a jejunal loop to the aortic Dacron graft, the scan was deemed to be inconclusive. In light of the history, we proceeded to perform an urgent antegrade double-balloon enteroscopy (DBE) for direct endoscopic assessment of the small bowel. Our suspicions were confirmed and a definitive diagnosis of an AJF was clinched when the external surface of part of the Dacron graft was seen to bulge through the jejunal wall at an estimated insertion depth of 60 cm post-pylorus (video).

Conclusions Secondary AEFs affect up to 1.6% of patients who undergo AAA repair; the jejunum is involved in only about 9% of these cases. In view of the associated mortality that ranges between 22%–100%, prompt, definitive diagnosis remains critical. To the best of our knowledge, this is the first report of AJF identified by DBE and highlights the effectiveness of this endoscopic modality in providing an irrefutable diagnosis of an AEF when this lies beyond the duodenum.

PTH-077 RESECTION OF GIANT PEDUNCULATED POLYPS USING A SCISSOR FORCEPS; A RESCUE POLYPECTOMY

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10.1136/gutjnl-2018-BSGAbstracts.100

Introduction Lumen filling giant pedunculated polyps can be challenging to resect and in some instances can be impossible leading patients to have surgery. Difficulties in polypectomy include an unstable position, large polyp head, unclear views and thick stalks. Here we describe an endoscopic technique which salvaged a challenging polypectomy.

Methods A 62 year old lady attended after presenting with per rectal bleeding and passage of mucous. Initial colonoscopy showed a large pedunculated polyp with a pit pattern of type 4/5 which was thought to be malignant. CT scan was normal. On repeat colonoscopy there were no clear signs of malignancy.

Results Despite numerous attempts it was impossible to capture the polyp with conventional snares even after applying volume reduction. Finally the polyp was resected by cutting the stalk using a SB Junior Knife (Scissors forceps). Three prophylactic clips were applied. Patient did not have any complications. Histology revealed a tubulovillous adenoma with low grade dysplasia.

Conclusions This technique provides a useful option for performing polypectomy in challenging stalked polyps and should form part of every endoscopist's armamentarium.

PTH-078 SNARE TIP ANCHOR POLYPECTOMY: A USEFUL TECHNIQUE TO ACHIEVE EN-BLOC RESECTION

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10.1136/gutjnl-2018-BSGAbstracts.101

Introduction Flat colonic polyps can be challenging to resect due to difficult position, unstable scope or slipping of the snare. Here we demonstrate a previously reported