(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-I, 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 gastroscope 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 physiologic saline vis-à-vis water-immersion).

REFERENCE

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


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 anterograde 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 AJF when this lies beyond the duodenum.