(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

Alberto Murino*, Nikolaos Koukias, Andrea Telese, Nikolaos Lazaridis, Edward J Despott. *Royal Free Unit for Endoscopy, The Royal Free Hospital, Institute For Liver And Digestive Health, UCL London, London, UK*

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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 antrograde 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

¹Shivkumar Budihal*, ¹Stefano Sansone, ²Krish Ragunath, ¹Adolfo Parra-Blanco. *¹Nottingham University Hospitals, Nottingham, UK; ²NIHR Nottingham Digestive Diseases Biomedical Research Centre, Nottingham UK*

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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 mucus. 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

Shivkumar Budihal*, Stefano Sansone, Adolfo Parra-Blanco. *Nottingham University Hospitals, Nottingham, UK*

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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

colonoscopic technique from Taiwan which facilitates easier placement of the snare thereby achieving en-bloc resection.

Methods A 67 year old lady presented to our institute with an altered bowel habit and was found to have a flat polyp in the sigmoid colon on colonoscopy.

Results Standard injection as per conventional endoscopic mucosal resection was initially performed. Then a suitably sized snare was selected and the snare tip was used to make a single incision with cut current lateral to the polyp. The snare tip was then anchored at the site of the incision and then the snare was slowly opened and simultaneously positioned around the polyp. Once the snare was adequately placed the polyp was resected. Histology revealed a tubulovillous adenoma with low grade dysplasia which was excised completely.

Conclusions This technique provides an easy and safe way to resect en-bloc flat, large and challenging colonic polyps.

PTH-079 FULLY COVERED METAL STENT INSERTION FOR THE TREATMENT OF REFRACTORY POST ENDOSCOPIC SPHINCTEROTOMY BLEEDING

Yasmin Kassir*, Alvin Ochieng, Phillip Berry, Terence Wong. *Guy's and St Thomas' NHS Foundation Trust, London, UK*

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Introduction Bleeding is a common complication of endoscopic sphincterotomy (ES), occurring in 4% of cases. Fully covered metal stents (FCMS) are mainly indicated in the treatment of biliary strictures, bile ducts leaks and biliary stones. Recent studies have shown the value of fully covered metal stent placement in the management of post ES haemorrhage after failure of primary endoscopic interventions.

Treatment options have previously been limited to arterial embolisation or surgery in cases where conventional endoscopic therapy has failed. FCMS placement provides a less invasive means of achieving haemostasis through mechanical tamponade and may be a suitable option in patients whose bleeding has not been controlled with first line endoscopic management.

Methods We report a case of post ES bleeding refractory to conventional therapy, where haemostasis was achieved through placement of a temporary FCMS. A 27 year old man underwent therapeutic ERCP for choledocholithiasis in which precut sphincterotomy (with needle knife) resulted in bleeding. Initial management with local injections of adrenaline, endoclips and heater probe therapy were unsuccessful in achieving prolonged haemostasis and the patient became haemodynamically unstable, with melaena and Hb drop from 103 g/L to 56 g/L. The patient underwent a repeat ERCP in which a fully covered (10 mm/6 cm) metal stent (Wallflex, Boston) was inserted across the ampulla to tamponade the site of bleeding. The stent remained in situ and was removed 6 weeks post initial insertion, with no residual bleeding. Of note, the patient developed acute cholecystitis 48 hours post stent insertion, requiring urgent cholecystectomy. There were no post-operative complications.

Results Our case demonstrates the successful management of post ES bleeding with the use of FCMS placement, avoiding the need for arterial embolisation or surgery. Despite achieving haemostasis, our patient developed acute cholecystitis

following stent placement, requiring urgent cholecystectomy. This has been reported in up to 10% of patients with FCMS for all indications. The patient remained well post operatively and stent was removed with no residual bleeding.

Conclusion Our case supports the proposed use of FCMS placement as second line management in post ES bleeding refractory to conventional endoscopic therapy. In applying this technique we avoided the use of arterial embolisation and its associated risks and complications, of particular importance in a young patient such as ours. There is a risk of cystic duct outflow obstruction in the application of covered metal stents, as our case highlights, and it is important to recognise this when considering this treatment modality.

PTH-080 A MULTIMODALITY ENDOSCOPIC APPROACH FOR MANAGEMENT OF BURIED BUMPER SYNDROME

Nikolaos Lazaridis*, Alberto Murino, Andrea Telese, Nikolaos Koukias, Edward J Despott. *Royal Free Unit for Endoscopy, The Royal Free Hospital and University College London (UCL) Institute for Liver and Digestive Health, Hampstead, London, UK*

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Introduction Buried bumper syndrome (BBS) is a rare, long-term complication of percutaneous endoscopic gastrostomy (PEG) placement, occurring in 2%–6% of the cases. BBS is thought to occur due to prolonged compression of the tissue between the external and internal fixators, leading to 'burying' of the PEG bumper into the gastric wall. Consequences of BBS include tube obstruction and more rarely bleeding, abscess formation, and perforation. Several endoscopic techniques are described for the management of BBS and these may be complimentary when used in combination.

Methods A 32-year-old woman with diabetes, chronic kidney disease, a history of hypoglycaemic brain injury and gastroparesis, requiring a venting PEG, presented with abdominal pain. PEG tube obstruction led to the suspicion of BBS and abdominal computerised tomography confirmed this.

Results At upper gastrointestinal endoscopy under general anaesthesia, the internal bumper was found to be completely buried by granulation and fibrotic tissue. A 2.5 mm FlushKnife (Fujifilm, Saitama, Japan) was initially used to partially dissect the overgrown gastric tissue in order to achieve insertion of a biopsy forceps down the external aspect of the PEG tube and through the dissected orifice. This manoeuvre opened a track in the overgrown tissue for insertion of a sphincterotome mounted on a JagWire (Boston Sci., MA, USA) through the external PEG tube. The sphincterotome was then flexed completely and several radial incisions on the overgrown tissue were performed using external traction on the sphincterotome. Finally, a 6 mm endoscopic balloon dilator was passed through the scope and pulled into the PEG tube by the biopsy forceps inserted through the external end of the tube. The balloon was then fully inflated within the PEG tube and traction was applied to the balloon and endoscope for release of the buried bumper and PEG tube remnant from the dissected overgrown tissue into the stomach. The dissected orifice was then closed using endoscopic clips. The procedure was performed under antibiotic prophylaxis.

Conclusion To the best of our knowledge, this is the first use of a complimentary, multimodality endoscopic approach for the effective, minimally invasive, safe management of BBS.