Results All procedures had technical success with no immediate complication related to OTSC application. Patients were followed up for every month with a mean duration of follow up 10.2 months. One patient with bronchoesophageal fistula had the development of another fistulous opening above the site of OTSC placement, which was successfully closed with another OTSC. One patient had superficial esophageal wall ulcer opposite the OTSC, but it healed spontaneously.

Conclusions OTSC provided safe and successful closure in a number of settings such as the closure of fistula, perforation, dehiscence.

IDDF2018-ABS-0016

REMOVABLE SELF-EXPANDING METAL STENTS INSERTION FOR THE TREATMENT OF PERFORATIONS AND POSTOPERATIVE LEAKS OF THE OESOPHAGUS

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Background Esophageal rupture, spontaneous or iatrogenic, is associated with significant morbidity and mortality. The current study aims at highlighting the various clinical scenarios, where esophageal fully covered self-expanding removable metal stents (FCSEMS) can be used in esophageal rupture.

Methods In patients who underwent insertion of FCSEMS between January 2013 and June 2014, all data regarding demographics, indications, insertion, removal, and outcomes were studied retrospectively (table 1). Seven patients underwent the placement of esophageal covered SEMs. Two patients had Boerhaave syndrome (figure 1), two had leak following the repair of an aortic aneurysm, one had extensive esophageal injury following transesophageal echocardiography, one had carcinoma oesophagus with tracheoesophageal fistula, and one had dehiscence of esophagogastric anastomosis.

Results Seven patients underwent the placement of esophageal covered SEMs. Two patients had Boerhaave syndrome, two had leak following the repair of an aortic aneurysm, one had extensive esophageal injury following transesophageal echocardiography, one had carcinoma oesophagus with tracheoesophageal fistula, and one had dehiscence of esophagogastric anastomosis. Stent insertion was successful in all the patients; one had stent migration which was managed endoscopically. Two patients died due to underlying illness; the rest had

successful removal of stents after 8–10 weeks and good outcomes.

Conclusions Esophageal FCSEMS placement is safe and effective modality in the management of patients with esophageal rupture.

Abstract IDDF2018-ABS-0016 Figure 1

IDDF2018-ABS-0017

SPLENOADRENAL SHUNT FOR NONCIRRHOTIC PORTAL HYPERTENSION

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Background Portosystemic shunt surgery is an established treatment option for preventing variceal rebleeding in patients with noncirrhotic portal hypertension (NCPH). The proximal splenorenal shunt is a widely performed procedure in these patients. In this study, the use of adrenal vein as an alternative conduit has been investigated.

Methods A retrospective analysis of patients with NCPH who underwent proximal splenoadrenal and splenorenal shunt between 2011 and 2015 was performed. Demographic findings, aetiology of portal hypertension, clinical presentation, haematological parameters, liver function test, intraoperative findings, postoperative morbidity, and shunt patency were studied and compared between the two groups. All patients were followed up for a minimum of 12 months with Doppler

Abstract IDDF2018-ABS-0016 Table 1

Patient	Age/ Gender	History	Indication of stenting	Interval between diagnosis of leak to placement of SEMs(days)	Length of stent (mm)	Removal done after (weeks)	Outcome
1.	44/M	Spontaneous distal eso rupture	Boerhaave syn	2	120	8	Recovery
2.	68/M	Haemetemesis following TEE	Mid and lower esophageal tear	1	120(two stents)	10	Recovery
3.	48/M	Thoracic aorta aneurysm repair	Mid-esophageal leak	8	120	-	Expired
4.	60/F	Spontaneous distal eso rupture	Boerhaave syn	1	120	10	Recovery
5.	42/M	Total gastrectomy with esophago- jejunostomy	Anastomotic leak	40	120	-	Expired
6.	44/M	Thoracic aorta aneurysm repair	Esophageal leak	2	120	8	Recovery
7.	57/M	Carcinoma oesophagus with esophago- pleural fistula	Esophago-pleural fistula	7	120	10	Recovery

study of the shunt to assess shunt patency and upper gastrointestinal endoscopy to assess regression of varices.

Results During the study period, 97 patients with NCPH underwent shunt surgery (proximal splenoadrenal shunt, 8; proximal splenorenal shunt, 74; and interposition mesocaval shunt, 15). Anomalous anatomy of the left renal vein was the main indication (5/8 patients) for a splenoadrenal shunt. Median fall in portal pressure in patients who underwent splenoadrenal shunt was 11.5 mmHg (range, 2–14 mmHg). The median (range) operative time was 4.5 (3–6) hours and median (range) intraoperative blood loss was 160 (100–200) mL. During a median (range) follow-up of 32 (12–48) months, shunt thrombosis developed in one patient. Comparison of intraoperative parameters and postoperative outcomes showed no significant difference in median fall in portal pressure ($p=0.39$), median operative time ($p=0.51$), median blood loss ($p=0.80$), Grade III/IV postoperative complications ($p=0.56$), shunt thrombosis ($p=0.93$), and varices regression rate ($p=0.72$) between patients undergoing proximal splenorenal and splenoadrenal shunt.

Conclusions The left adrenal vein is a suitable vascular conduit for porto-systemic shunt surgery. This is especially so if the performance of splenorenal shunt is precluded because of anatomic abnormality of the renal vein.

IDDF2018-ABS-0018 BOERHAAVE'S SYNDROME: A RARE CAUSE OF HYDRO-PNEUMOTHORAX IN NEWBORN

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Background Hydro-pneumothorax following spontaneous esophageal rupture (Boerhaave's Syndrome) is very rare and often fatal. Early diagnosis and treatment of esophageal perforation can be life-saving.

Methods We report a case of a 4 day old term female baby weighing 2800grams. She was admitted with complaints of excessive cry, vomiting, refusal to feed and fast breathing for one day. The baby was exclusively breastfed since birth and was well until one day before admission. On examination, there was severe respiratory distress, cyanosis and pooling of oral secretions. On palpation, crepitus was appreciated on the skin overlying on the right side of the chest wall (suggestive of subcutaneous emphysema). On auscultation, entire right side of the chest had decreased air entry which raised suspicion of pneumothorax.

Chest X-ray revealed subcutaneous emphysema, right-sided pneumothorax with underlying collapse and orogastric feeding tube was located in the right thoracic cavity (figure 1). Ultrasound chest showed right-sided air with pleural collection with 2 mm septations. A tube thoracostomy was done on day 2 of admission. Later, the baby was put on a ventilator in view of type I respiratory failure. CECT thorax was done which showed right-sided hydro-pneumothorax with free air pocket in peri-esophageal region in the upper thoracic oesophagus. After giving contrast through ryles tube, free spillage of contrast was seen in right pleural cavity suggestive of rupture of oesophagus.

Results Since the baby was hemodynamically stable, conservative management was done. After 10 days of conservative management, she was referred and transferred to surgical

management where the primary repair was done. Follow up after surgery showed clinical improvement.

Conclusions Spontaneous rupture of oesophagus (Boerhaave's Syndrome) in neonates is rare with high mortality. Radiological findings include subcutaneous emphysema, hydro pneumothorax, mediastinal/sub diaphragmatic air. The diagnosis is confirmed by the extravasation of contrast material while performing contrast esophagography with or without CT chest.

A conservative non-operative approach is preferred. Surgical closure is by primary repair/resection of the defect, diversion or esophagectomy. This case report aims to create awareness about the importance of early recognition of this life-threatening condition, which if treated timely can be life-saving.

Abstract IDDF2018-ABS-0018 Figure 1

IDDF2018-ABS-0019 ENDOSCOPIC ULTRASOUND-GUIDED FINE-NEEDLE ASPIRATION OF ENLARGED ADRENALS IN PATIENTS WITH PYREXIA OF UNKNOWN ORIGIN: A SINGLE CENTRE EXPERIENCE OF 52 CASES

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Background Fine needle aspiration (FNA) of adrenals is needed in patients with pyrexia of unknown origin (PUO) and adrenal enlargement in the absence of other diagnostic clues. Adrenals are easily accessible by endoscopic ultrasound (EUS) due to proximity; however, there is no systemic study available. The aim of this study was to evaluate the diagnostic yield and safety of EUS-FNA of enlarged adrenal in patients with pyrexia of unknown origin (PUO).

Methods Data were analysed from October 2010 to September 2016 at a single tertiary care centre in North India. EUS FNA of enlarged adrenals was done in fifty-two patients for the