* $p < 0.05$; ** $p < 0.1$; *** $p < 0.001$

Note: The numbers are Beta coefficients of MLM models, each line representing one model. Bold numbers represent negative predictions. The direction of arrow denotes the direction of temporal predictions. Only significant predictions are shown in the figure.

Abstract IDDF2018-ABS-0164 Figure 1

IDDF2018-ABS-0169

CLINICAL CHARACTERISTICS OF ENTEROPATHY-ASSOCIATED T-CELL LYMPHOMA (EATL) WITH INTRACRANIAL METASTASIS: AN ANALYSIS OF PUBLISHED CASE REPORTS

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Background To describe the clinical characteristics of EATL with intracranial metastasis from cases published in literature. **Subjects** EATL is a rare disease of the gastrointestinal tract. Intracranial metastasis associated with EATL is even rare. Six cases including one of ours were recruited in the study. Five reported cases were found between 1997 and 2012 in the English literature (table 1).

Methods Ours was a 35-year-old man who presented initially with diarrhoea, and he was later confirmed to have EATL from biopsy at jejunum that showing positive in CD3, CD8 and CD56 with negative in CD4. Since diagnosis, he had received 11 cycles of adjuvant chemotherapy. He underwent laparotomy with resection and anastomosis of jejunum due to the acute abdomen. An episode of left-sided weakness after having received his 11th cycle of chemotherapy led to brain

Abstract IDDF2018-ABS-0169 Table 1

Cases	Age	Sex	Celiac Disease	Primary lesion	Symptoms and Sign	Tx	Location of intracranial metastasis	Neurological symptoms	Tx	Overall survival after initial diagnosis
(1) Tutt et al*	45	M	(+)	Small bowel	Abd pain, diarrhoea;	Supportive	Supratentorial (Rt ventricle)	Headache, confusion, memory impairment,	C/T, radiotherapy	11 M
(2) Shams et al*	54	M	(-)	Jejunum	Perforation	OP(+), C/T	Infratentorial (Lt cerebellum)	Ataxia, slurred speech	Nil	3 M
(3) Gobbi et al*	56	F	(+)	Stomach Duodenum	Perforation	OP(+), C/T	Supratentorial (Subcortical and periventricular)	Headache, Depression, Cognitive decline	C/T, radiotherapy	9 M
(4) Berman et al.	70	M	(-)	Jejunum	Abd pain, weight loss	OP(+), C/T	Supratentorial (Bil occipital and temporal)	Seizure	Steroid (+), radiotherapy	16M
(5) Defillo et al.	65	F	(-)	Jejunum	Abd pain, Obstruction	OP(+), C/T	Supratentorial (Rt frontal- parietal)	Change in MS; Left facial brachial weakness;	OP (+)	Nil
(6) Chuah et al.	35	M	(-)	Jejunum	Diarrhoea	OP(+), C/T	Supratentorial (Frontal and corpus callosum)	Change in MS; Left sided weakness;	Steroid (+)	9M

computed tomography scan, which it showed brain metastasis. He expired 9 months later after initial diagnosis. Altogether, six cases of EATL with intracranial metastasis were reviewed for their clinical characteristics.

Results The mean age was 54 years old (range from 35 to 65 years old). Two-thirds were males. Many (two-thirds) were without a history of celiac disease. One-half of the patients had abdominal pain as the initial gastrointestinal presentation. The primary lesion site was in the small intestine with jejunum predominance (66.6%). Eighty-three percent of patients had abdominal surgery and adjuvant chemotherapy for the primary lesion. The majority site of intracranial metastasis was supratentorial V.S. infratentorial; 83% V.S. 17%. Half of intracranial metastasis (50%) presented with a change of mental status. Headache (33.3%) and weakness of extremities (33.3%) were the next most common presentations of metastasis. Radiotherapy, chemotherapy and steroid therapy were used to treat intracranial metastasis. The survival was an average of 9.6 months (3 months to 16 months) after the initial diagnosis of EATL.

Conclusions The prognosis of EATL with intracranial metastasis is generally poor with a mean survival time of fewer than 10 months.

IDDF2018-ABS-0170

SINGLE CENTRE INITIAL EXPERIENCE OF EUS-GUIDED GALLBLADDER DRAINAGE FOR CHOLECYSTITIS USING A LUMEN APPOSING METAL STENTS (LAMS), FOR NONSURGICAL CANDIDATES

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Background With the introduction of new LAMS, EUS guided gallbladder (GB) drainage is now becoming a viable alternative to percutaneous GB drainage with favourable clinical success rates and potentially fewer adverse events.

Methods Patients with cholecystitis who were not surgical candidates due to advanced malignancy or severe co-morbidities underwent EUS guided GB drainage in a single centre from April 2017 till OCT 2017. LAMS 15 mmx10 mm with the electrocautery-enhanced delivery system were used in all patients.

Results A total of 6 patients with a median age was 65 years (range, 58–93). Three patients had severe cardiovascular disease and rest had advanced hepatobiliary malignancy. The Charlson Comorbidity Index median value 8 (4–10). Cholecystitis was graded moderate in three patients and mild in three per the Tokyo guidelines. Three patients were performed as primary GB drainage, and three were performed as endoscopic internalisation of prior percutaneous biliary drainage. LAMS deployment was technically successful in four patients. Two patients had contrast extravasation on the initial filling of GB via the percutaneous drain and after needle puncture respectively. As the GB was not distended in each case, the respective procedures were aborted and referred for surgical management. Of the four deployed stents, one had the proximal flange obstructing the pylorus, and this was treated with another LAMS deployed at the pylorus to prevent gastric outlet obstruction. There was no periprocedural complication. The median duration of the successful procedures was 33.5 min (20–83). Three patients had advanced malignancy, so

the LAMS was left permanently. One patient had transmural stone extraction through the LAMS. During this procedure, a stone migrated into the common bile duct. This patient underwent ERCP and LAMS removal at one month after placement. One patient had severe abdominal pain due to post-procedure bile leak and was treated conservatively with intravenous antibiotics. The overall success rate was 67% (4/6). Of the four successfully deployed LAMS, clinical success was observed in all.

Conclusions GB drainage using LAMS is technically feasible for non-surgical candidates with cholecystitis. Inability to distend the GB adequately for safe LAMS deployment was the main reason for the failure of the procedure.

Abstract IDDF2018-ABS-0170 Figure 1

IDDF2018-ABS-0171

EUS-GUIDED GASTROJEJUNOSTOMY USING A LUMEN APPOSING METAL STENT IN PATIENTS WITH SYMPTOMATIC GASTRIC OUTLET OBSTRUCTION

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Background EUS gastrojejunostomy (GJ) is emerging as an alternative novel technique in patients with symptomatic gastric outlet obstructions (GOO) who have advanced malignancy. Recent studies have shown that the EUS-guided approach has less adverse events and is more cost-effective compared to laparoscopic GJ. We share our experience of 5 patients who underwent EUS Guided GJ with favourable outcomes.

Methods 5 patients with symptomatic gastric outlet obstruction underwent EUS-guided GJ interventions from May, 2017 to Nov. 2017. Patients were informed of the potential risks and informed consent was taken. Technical success was defined as successful deployment of lumen apposing metal stents (LAMS); while clinical success was the ability to tolerate diet.

Results Median age was 61.5 (Range 53–83) years. GOO was secondary to advanced pancreatic malignancy (4) and duodenal malignancy (1). Two patients had altered anatomy from previous post bilroth gastrectomy and Roux-en-Y hepaticojejunostomy. For all five patients with GOO, LAMS 15 mm diameter with electrocautery-enhanced delivery system was used to create the GJ anastomosis. Identification of the distal jejunal limb was done with an inflated balloon catheter and this was used as a target for direct puncture with a 19G needle. All five interventions had technical success with median procedure time of 80 min (38–163 range). All stents were dilated up to