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

their corresponding diameters. Duration of stay after procedure was 3–7 days and there were no adverse events post procedure such as bleeding or perforation. There were no stent migrations and stents were left in place for the rest of their life expectancy. One patient developed intermittent vomiting four weeks after stent deployment. This was possibly secondary to proximal stomach deployment, as repeated endoscopy showed a patent stent. The rest of the patients had clinical success and could tolerate diet on discharge. Range of follow up time was 1–6 months and at time of analysis GOO did not recur in all 5 patients. Three patients died due to disease progression with no symptoms of GOO prior to terminal event.

Conclusions EUS guided GJ is a novel procedure with favourable outcomes in patients with symptomatic GOO.

Abstract IDDF2018-ABS-0171 Figure 1

IDDF2018-ABS-0172 DIETARY FACTOR RELATED TO ULCERATIVE COLITIS INFLAMMATION. AVOIDANCE OF FACTOR COULD BENEFIT DISEASE CONTROL?

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Background The environment factors like western diet are considered related to development and relapse of ulcerative colitis (UC) but still lack enough supporting report. In this study, we evaluate the benefit of disease control from avoidance of possible factors.

Methods Patients with UC were enrolled between January 2006 and June 2017 and followed up for at least half year by a single colorectal specialist. Every patient was evaluated by sigmoidoscopy or colonoscopy based on Mayo endoscopic subscore (score 0–1 without rectal bleeding defined as remission). Patients were asked to avoid dairy intake at first doctor visiting. For those who had remission, we searched possible factor when relapsed and suggested avoiding the factor. The remission rate and duration were calculated to analyse.

Results 112 patients (74 males, mean age 45.6 ± 13.7 years) were followed up for a mean duration of 5.1 ± 3.4 years. 90 patients achieved remission at first six months. 39 patients who had no any relapse episode during the rest follow up (mean followed up 4.3 ± 3.2 years) were well controlled by mesalazine and avoidance of milk derivative. 49 patients had

relapse and remission episode, total 97 times of relapse (mean followed up 6.5 ± 3.2 years). 2 patients did not achieve remission after relapse. The possible factors related to relapse were milk derivative, Chinese herb and tonic food, dietary supplement and non-dietary factor. Overall, the group with complete avoidance of possible factors has higher remission rate in 180 days compared to incomplete group (98% vs. 45%, $p < 0.001$). The time for achieving remission in complete avoidance group was significantly less than that in the incomplete group (45.7 ± 35.0 days vs. 82.2 ± 40.8 days, $p = 0.022$). Based on this protocol, steroid use was decreased, and 15 remission patients can stop medication without relapse for 1.9 ± 1.2 years.

Conclusions Environment factors related to UC are multiple and might be individual. Avoid possible factor can improve UC control by decreasing steroid use and shortening the time to achieve remission. Specific Chinese herb and tonic food might be a possible factor for UC patient in Asia Area.

IDDF2018-ABS-0174 FECOBIONICS: NOVEL DEFECATORY FUNCTION TEST

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Background Defecation is a complex process. Defecatory disorders may be assessed using rectal balloon expulsion test (BET), high-resolution anorectal manometry (HR-ARM) and defecography. We have developed a Fecobionics device that integrates several current tests¹ to assess pressures, orientation and bending all at once by the patient bedside. The Fecobionics probe is 10 cm long, 12 mm in diameter with 8 cm long inflatable bag and pressure sensors at each end. It contains two gyroscopes to measure the orientation and bending during defaecation.

Aim To characterise physiological expulsion parameters in asymptomatic subjects using Fecobionics.

Methods Fecobionics was inserted into the rectum and subjects were asked to sit on a commode. The bag was filled with fluid until subjects had the sensation to defaecate. Patients were asked to expel the Fecobionics. Time to expulsion, pressures and bending angles were assessed during the expulsion. This was compared to conventional 5=BET and HR-ARM.

Results Eight subjects (6F/2M, 50 years (25–77)) were assessed. Defaecation urge was felt at $32 \pm$. Five subjects expelled Fecobionics in one attempt. The expulsion time for Fecobionics and BET were 32.2 ± 6.3 and 15.7 ± 3.3 s respectively ($p < 0.05$). Linear association was found between the duration of Fecobionics and BET expulsions ($R^2 = 0.48$). During Fecobionics expulsion all pressure sensors showed elevated pressures. The front end pressure reached 20–50 cm/H₂O above baseline rectal pressure during anal canal passage. Rear end pressure was 28.9 ± 4.6 cm/H₂O before expulsion to a maximum pressure of 144.7 ± 15.7 cm/H₂O during the expulsion. Defaecations could be subdivided into five distinct phases based on the front and rear pressures and their pressure difference¹. The bending angle was $137.2 \pm 9.6^\circ$ before defaecation, $145.3 \pm 5.0^\circ$ at maximum contraction, and $178.7 \pm 0.9^\circ$ during anal passage ($p < 0.05$); indicative of changes in the anorectal angle.