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MANAGEMENT OF CAUSTIC CONSUMPTION INJURIES – A MULTIDISCIPLINARY EFFORT FOR A SUCCESSFUL OUTCOME

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Background Ingestion of corrosive substances results in severe damage of the upper aero digestive system and is still a major cause of concern in India. Injuries depend on the type of substance, quality, quantity and intention. Corrosive agents produce extensive damage to the gastrointestinal tract, which may result in death in the acute phase or may result in long-term sequelae. We describe the experience of our department in treating such injuries.

Methods All corrosive injury patients, acute and late, presented to the Department of Surgical Gastroenterology from Jan 2009 - May 2018, are included in this retrospective study.

Results Between Jan 2009 - May 2018, 85 patients were admitted with a history of corrosive agent consumption. 48 patients had an only mild mucosal injury and were treated conservatively and required no further intervention.

4 required emergency total gastrectomy with a cervical esophagostomy of whom only one survived.

26 patients underwent repeated esophageal dilatations for strictures. 1 of them had a spontaneous duodenal perforation and succumbed. 19 patients responded very well to the dilatation protocol. 6 patients underwent surgery for complication/failure of endoscopic dilatation.

7 patients presented late with well-established strictures with poor nutrition and underwent a feeding jejunostomy with a reconstructive procedure at a later date.

A total of 13 patients underwent a reconstructive procedure, 7 underwent a colonic pull through, 2 gastric pull up and 4 underwent a Bilroth II distal gastrectomy.

Conclusions Corrosive injury of the upper gastrointestinal tract is a complex condition, requiring an intensive approach and multidisciplinary management. Maintenance of nutrition is essential for a good outcome. The native esophagus should be salvaged whenever possible. Meticulous intra-operative technique and ensuring good vascular supply of the conduit are the cornerstones of the successful outcome.

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DIFFERENCES IN PRESENTATION OF PRIMARY VS STUMP GASTRIC CARCINOMAS: SHORT TERM ANALYSIS

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Background With the advent of effective medical treatment-PPI and H. pylori eradication, surgeries for Peptic Ulcer Disease (PUD) have drastically declined.

Patients who underwent such surgeries a few decades earlier are still encountered in clinical practice, either benign or malignant.

Presentation varies with the type of previous surgery done. **Gastric Stump Carcinoma (GSC)**- Increased risk of malignancy after gastrectomy, Carcinoma of the gastric remnant or the stump after partial gastrectomy with risk increasing 15 years after gastrectomy.

Previous studies have demonstrated that rates of gastric stump carcinoma are consistently higher after treatment with a **Bilroth II procedure >> Bilroth I procedure**

Aim To analyze whether any difference exists between presentation and management of primary gastric carcinoma and stump carcinoma

Methods Retrospective study

patients are divided into 2 groups

I- Patients with GSC following truncal vagotomy and gastrojejunostomy for PUD

II-Patients without previous gastric surgery with primary gastric carcinoma

Clinico-pathological parameters of these groups were compared and analyzed

Inclusion criteria - All patients with Resectable gastric and stump carcinomas in previous TV+GJ and good performance status

Results Stomal malignancies presented with GI bleed in all cases(100%), followed by weight loss (75%) and vomiting (25%).Non-stomal malignancies presented with anorexia (83.3%), GI bleed (75%) and weight loss (75%).

Total gastrectomy done in 1 stomal & 7 non-stomal malignancies. Subtotal gastrectomy done in 3 stomal and 5 non stomal malignancies.

3 in T3 and 1 in T1 stage in stomal group, 2 in NO and N1 stage each. In non stomal group T4 (n=7),N1 (n=7) and N2 (n=5) presentation.

Conclusions High suspicion for malignancy and low threshold for endoscopy in patients with previous gastrojejunostomy - provide an opportunity for early diagnosis and curative resection in stump carcinomas

Altered lymph flow and anatomic relationship with adjacent organs due to initial surgery. Surgical resection is considered an effective therapeutic strategy for GSC. Invasive extent and surgical curability of GSC-Prognosis of patients

GSC have decreased rate of curative resection and long-term survival rate if identified at an advanced stage due to unapparent symptom and High incidence of lymph node metastasis

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MODIFIED PULLEY TRACTION SYSTEM IN ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) OF COLONIC LESIONS

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Background ESD is a proven and safe technique for endoscopic treatment of early gastrointestinal tract cancers. Technical challenges remain especially when resecting large lesions in difficult locations. Traction system providing unilateral traction has been previously described as a useful tool. We present a case series of using the modified pulley traction system in assisting ESD in colonic lesions.

Methods Dental floss was used as a traction line. It was inserted through the biopsy channel and a loop was tied outside the endoscope before starting the procedure. Circumferential incision with Flush Knife BT 1.5mm Fujifilm(R) was carried out at the targeted lesion after submucosal lifting. The dental floss loop outside the endoscope was cut and tied to an endoclip which was then placed over the lesion's distal

margin(anal side). Another endoclip was placed over the existing line on the opposite colonic wall distally creating a pulley traction system.

Results Three colonic ESD cases were carried out. Site of lesions were rectum(3.7x3.0 cm), ascending colon (4.0x3.5 cm) and distal sigmoid colon (1.8x1.5 cm). Average completing time was 169.3 minutes. There were no perforation in all cases performed. Enbloc resection was achieved in all cases.

Conclusions The modified pulley traction system was helpful in achieving en bloc resection, especially at difficult locations. This method provides an alternative where similar devices or accessories are limited outside Japan, whereas dental floss and endoclips are readily available throughout the world.

IDDF2019-ABS-0304 GASTROESOPHAGEAL REFLUX DISEASE AND CHRONIC GRAFT FAILURE IN LUNG TRANSPLANTATION: KEEP THE TARGET IN SIGHT

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Background Gastroesophageal reflux disease (GERD) has been reported in up to 88% of patients after lung transplantation (LTx). Concern has been raised on the aspiration of refluxate which contributed to the nonalloimmune cause for the development of chronic lung allograft failure (CLAD), such as bronchiolitis obliterans syndrome (BOS). This study included a comprehensive review of the current literature on the association of CLAD/BOS and GERD by discussing the pathophysiology, evaluation, and management of GERD.

Methods Patient data included age, sex, body mass index, donor and recipient cytomegalovirus immune status, indication for LTx, clinical test data, LTx date, intraoperative data, post-LTx medication, post-LTx complications, including acute rejection, CLAD occurrence, and death and anti-reflux therapy were recorded.

Results Publications from PubMed, Scopus and Web of Science on "lung transplantation, gastroesophageal reflux" were reviewed and analyzed. Cases from our center were reviewed and summarized.

Common associations of reflux and transplanted lung status were illustrated by: hazard ratio of reflux on time to development of BOS, effect of reflux on FEV1, relationship between prevalence and extent of GERD and types of transplant; association between the prevalence and type of reflux and gastric aspiration in patients with and without BOS; quantification of reflux, aspiration, and allograft injury. Post-lung transplant exposure to persistent PPI therapy had a beneficial effect. Exposure to severe acid reflux pretransplant was associated with early readmission following lung transplantation in need of aggressive early antireflux therapy. For pediatric recipients, gastric dysmotility related to allograft dysfunction.

Bronchoalveolar lavage fluid (BALF) is another useful tool for the current study in LTx patients. There have been shown relationships of levels of bile acids, IL-8, neutrophils on the development of BOS; aspiration on immune mediator concentrations related to BOS; acid exposure, volume exposure, or reflux events correlated to and neutrophilia, bile acids and other dysregulation of immune mediator concentrations; the level of pepsin related to acute rejection.

Conclusions Our review of the literature and preliminary data supports that GERD related to lung allograft injury and long-term failure, encouraging a strategy of early diagnosis and aggressive reflux management, aiming to prolong the duration of normal graft function.

IDDF2019-ABS-0309 GASTRO-INTESTINAL ULCERATIONS/ STRICTURES IN OPIOID ABUSERS

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Background Opioid-induced bowel dysfunction include constipation, gastro-oesophageal reflux, abdominal distension and intestinal pseudo-obstruction. We report patients presenting with gastro-intestinal strictures and ulcers secondary to opioid abuse, an entity not well described in the literature.

Abstract IDDF2019-ABS-0309 Table 1

(n=18)	
Mean Age (± Standard Deviation) (Years)	38.46 ± 14.86
Males (N) (%)	18 (100)
Clinical Presentation	
Pain Abdomen (N)(%)	10 (55.55)
Vomiting (N)(%)	11 (61.11)
Loss Of Weight (N)(%)	10 (55.55)
Loss Of Appetite (N)(%)	3 (16.66)
Fatigue (N)(%)	14 (77.78)
Anemia (Hemoglobin <10 g%) (N)(%)	16 (88.89)
Gastric Outlet Obstruction (N)(%)	9 (50.0)
Small Bowel Obstruction (N)(%)	5 (27.78)
GI Bleed (N)(%)	5 (27.78)
Mean Weight Loss (± Standard Deviation)(Kg)	22.85 ± 9.06
Co-Addictions	3 (16.66)
Alcohol (N)(%)	-
Tobacco (N)(%)	-
Co-Infections (N)(%)	2 (11.11)/-/-
HCV/HBV/HIV	
Mean Opium Consumption (± Standard Deviation)Kg/month	1.46 ± 0.43
Mean Duration of Opioid Addiction (± Standard Deviation)(Years)	4.69 ± 6.09
Mean Duration of Symptoms (± Standard Deviation)(Days)	222.07 ± 392.93
Endoscopic Findings	
Ulcers (N)(%)	4 (22.22)
Esophageal (N)(%)	-
Gastro-Duodenal (N)(%)	2 (11.11)
Jejuno-Ileal (N)(%)	2 (11.11)
Colonic (N)(%)	-
Strictures (N)(%)	14 (77.78)
Esophageal (N)(%)	-
Gastro-Duodenal (N)(%)	9 (50.00)
Jejuno-Ileal (N)(%)	5 (27.78)
Colonic (N)(%)	-
Treatment	
Balloon Dilatation (N)(%)	10 (55.55)
Mean Number Of Dilatation Sessions (± Standard Deviation) (N)	1.57 ± 0.78
Failed Balloon Dilatation (N)(%)	6 (33.33)
Surgery (N)(%)	8 (44.44)