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EUS-GUIDED RADIOFREQUENCY ABLATION AS ADJUNCTIVE TREATMENT FOR UNRESECTABLE PANCREATIC CANCER VERSUS CHEMOTHERAPY ALONE (ERAP)

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Background Feasibility and safety of EUS-guided radiofrequency ablation (EUS-RFA) for unresectable pancreatic cancer (UPC) has been reported in only few small non-comparative studies.

Aim Compare radiological response and pain medication used between EUS-RFA plus chemotherapy versus chemotherapy

(CMT) alone as primary treatment of UPC in prospective comparative study.

Methods Patients with UPC with ECOG below 3 were recruited. Patients treated with EUS-RFA plus concurrent CMT were classified as group A. Control group was patients treated with CMT alone with matching clinical parameters (group B). All relevant parameters were compared (figure1A).

Results From July 2017 to August 2018, 28 patients (mean age 66.14±10years; M:F= 1:3) at King Chulalongkorn Memorial hospital were recruited. No statistical difference of baseline parameters (table 1). 34 EUS-RFA procedures were performed in 14 patients with median number of procedure 3 times (range 1–4 times), median total ablation time 270 seconds (range 90 - 962 seconds), and adverse event (AEs) rate 8.8% (3/34). Three AEs were post-procedure infection (length of stay (LOS) 7 days), bleeding puncture site (LOS 7 days) and mild pancreatitis (LOS 2 days). No delay of scheduled chemotherapy. 3 patients drop out due to disease progression in group A (n=11) and 1 patient loss to follow up in group B (n=13). Outcomes of both groups were compared (figure 1B). Morphine equivalent analgesia dose reduction was significantly better in group A, 22.5 mg/day (range 0–60) versus 0 mg/day (-20 to 30) (p=0.003), respectively, as well as median percentage dosage reduction (50% (0 to 100) versus 0% (-100

A

Characteristics	Subgroup	Total (n=28)	RFA group (n=14)	Control group (n=14)	P Value
Gender	Female (%)	19 (67%)	10 (71%)	9 (64%)	NS
	Male (%)	9 (32%)	4 (28%)	5 (35%)	
Age	Mean ± SD	66.14±10	66.53±10.4	65.71±10.06	NS
	Median	67	67	67	
ECOG	I	20 (71%)	10 (71%)	10 (71%)	NS
	II	8 (28%)	4 (28%)	4 (28%)	
Diagnosis	PDAC	26(92%)	13 (92%)	13 (92%)	NS
	Malignant IPMN	2(7%)	1 (7%)	1 (7%)	
Tumor stage	II	2(7%)	1 (7%)	1 (7%)	NS
	III b	8(28%)	4 (28%)	4 (28%)	
	IV	18(64%)	9 (64%)	9 (64%)	
Tumor longest diameter (mm.)	Mean ± SD	54.43±19.2	59.21±18.01	49.65±19.66	NS
	Median	52.66	54.22	44.74	
Tumor volume (ml)	Mean ± SD	77.12±58.5	80.79±54.08	73.7±64.12	NS
	Median	58.56	67.88	54.9	
Morphine equivalent dosage analgesia (mg/day)	Mean ± SD	34±32.2	48.73±35.14	20.41±22.67	NS

B

Parameters	Group A (RFA+CMT) (n=11)	Group B (CMT) (n=13)	P Value
Median of morphine equivalent analgesia dosage reduction (mg/day (range))*	22.5 (0 to 60)	0 (-20 to 30)	.003
Median percentage of morphine equivalent analgesia dosage reduction (% (range)) *	50 % (0 to 100)	0 % (-100 to 42.9)	.001
Mean maximal diameter of target lesion before and after treatment (mm.)	61.37±20.1 vs 64.25±22.0 (P = NS)	50.1±21.1 vs 55.4±18.2 (P = 0.017)	NA
Mean tumor volume before and after treatment (ml)	83.39±57.5 vs 107.14± 68.4 (P = NS)	80±65.5 vs 86.15±72.22 (P = NS)	NA
6-month survival rate	70%	70%	1.0

(Abbreviations: CMT = chemotherapy, RFA=radiofrequency ablation, PDAC=pancreatic adenocarcinoma, IPMN= Intraductal papillary mucinous neoplasm, NS=not significant)

Abstract IDDF2019-ABS-0171 figure 1 A) Demographic data and baseline characteristics of patients with unresectable pancreatic cancer receiving EUS-guided radiofrequency ablation plus chemotherapy (group A) versus chemotherapy alone (group B); B) Outcomes of patients with pancreatic cancer receiving EUS-guided radio frequency ablation plus chemotherapy (group A) versus chemotherapy alone (group b)

to 42.9), $p=0.001$), respectively. No enlargement of mean maximal target lesion diameter (mm) in group A (before vs. after; 61.37 ± 20.1 vs 64.25 ± 22.0 ($P = 0.099$), but significant increase in group B (50.1 ± 21.1 vs. 55.4 ± 18 ($p=0.017$), respectively). No significant difference of 6-month survival rate.

Conclusions EUS-RFA plus concurrent CMT significantly reduce morphine dosage requirement than CMT in UPC. RFA additionally stabilized the tumor maximal target diameter whereas CMT failed.

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GUT MICROBIOTA SHIFT AND LOW FIBRE INTAKE IN POST GESTATIONAL DIABETES WOMEN

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Background Women with previous history of gestational diabetes mellitus (GDM) have unhealthy dietary patterns and profound gut microbiota shift. They have seven-fold higher risk to develop type 2 diabetes mellitus (T2DM) in the future. We hypothesised that probiotics intervention will modulate gut microbiota and reverse glucose intolerance (GI) in post GDM women. The aim of the study was to investigate the dietary patterns and gut microbiota composition in post GDM women. Secondly, we aimed to determine the effects of probiotics on the baseline anthropometric and biochemical markers of post GDM women.

Methods Baseline clinical characteristics including glucose tolerance assessment, anthropometric measurement and a 3-day dietary record of 45 post GDM women were obtained. Post GDM women were grouped based on glucose tolerance [normal glucose tolerance (NGT) and glucose intolerance (GI)]. 36 participants were assigned for 12 weeks of either probiotics or placebo intervention. Anthropometric and biochemical markers of pre and post-treatment were evaluated. Faecal samples were sent for 16S sequencing pre and post-treatment.

Results 42.2% of 45 post GDM women have postpartum GI and significantly obese as compared with the NGT group ($p<0.01$). Mean daily fiber intakes of post GDM women was significantly suboptimal according to the Malaysian dietary recommendation ($p<0.001$). Pre-treatment, total cholesterol and high-sensitivity C-reactive protein (hsCRP) of 36 participants were above the recommendation value (4.95 ± 1.01 mmol/L, 5.54 ± 5.29 mg/L). Post-treatment, change in body mass index (BMI), waist-hip ratio (WHR), HbA1c and hsCRP of ten participants differed significantly between probiotics and placebo group ($p<0.05$). At the phylum level, the gut composition of 12 post GDM women was enriched with an abundance of *Bacteroidetes* and a relatively small proportion

of *Firmicutes*, *Verrucomicrobia*, and *Proteobacteria*. Based on the genus level, relative abundance of *Prevotella_9* genus in post GDM women with GI was 20.1% compared to only 2.1% in NGT group.

Conclusions Post GDM women with glucose intolerance were obese, consumed suboptimal fibre and have gut microbiota shift similar to the T2DM adult. Roles of probiotics in post GDM women needs further validation.

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SYSTEMATIC REVIEW OF CALCINEURIN INHIBITORS (CNI) AND VEDOLIZUMAB (VDZ) COMBINATION THERAPY IN ACUTE SEVERE ULCERATIVE COLITIS (ASUC)

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Background Patients with acute severe ulcerative colitis (ASUC) may be refractory to treatment with steroids and anti-tumour necrosis factor agents (anti-TNF). Ciclosporin inhibitors (CNI) have been used effectively as a fast-acting bridge to slower-onset immunomodulators in thiopurine-naïve patients; concerns over toxicity limit prolonged use as maintenance. Patients who are azathioprine-exposed or anti-TNF-refractory have limited medical treatment options, often resulting in colectomy. Combination of CNI as induction and slower-acting but potentially safer vedolizumab (VDZ) has recently been used in patients with severe inflammatory bowel disease (IBD). We aim to review the utility in ASUC.

Methods A systematic bibliographic review was conducted on PubMed using the keywords "vedolizumab", "calcineurin inhibitors", "inflammatory bowel disease", "severe ulcerative colitis" within the period 2013 to October 2018.

Results There were 2 prospective observational studies ⁽¹⁻²⁾ [N= 30] and 1 retrospective study ⁽³⁾ [N=39]. Patients were refractory to conventional treatment with steroids and/or anti-TNF therapy. CNI (ciclosporin or tacrolimus) was used for induction of remission in majority of cases, or as rescue agent in those failing induction with Vedolizumab [subgroup of 1 study, N=7].

In 2 studies, IV cyclosporine or Tacrolimus was started; a week later, CNI-responsive patients were given VDZ induction/maintenance and CNIs were stopped after 8–12 weeks per protocol. In another study, VDZ was initiated on average 30 days after CNI, with average combination CNI+VDZ of 64 days

Combination CNI+VDZ showed good short-term efficacy. At 1 year, there was a respectable colectomy-free rate of 75%, comparable to other studies with infliximab/ciclosporin combined with azathioprine. In those receiving steroids at baseline, Steroid-free remission was achieved in $18/36 = 50\%$ at week 14. Serious adverse events (N=7) were attributed to CNIs; there were no deaths.

Conclusions Preliminary studies of combination CNI and VDZ in patients with ASUC appear promising. Further prospective trials are needed for the confirmation of the utility and efficacy of this treatment strategy in the management of ASUC