PWE-038 **ENDOSCOPIC RESECTION OF AMPULLARY AND DUODENAL ADENOMAS: A TERTIARY REFERRAL CENTRE EXPERIENCE**

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Introduction Duodenal and ampullary adenomas have the potential for malignant transformation to carcinomas by an adenoma-to-carcinoma sequence as seen elsewhere in the gastrointestinal tract. Endoscopic resection of these lesions is increasingly being used in place of invasive surgery. However, endoscopic resection in the duodenum can be challenging due to its anatomy and may be associated with a higher risk of complications. This study aims to evaluate the safety and efficacy of endoscopic resection of such lesions.

Methods All patients with ampullary and large non-ampullary (>10 mm) duodenal polyps who underwent endoscopic resection between February 2008 and January 2019 in a single tertiary referral centre were included in the study. A retrospective analysis on data including demographics, size, histology, location, method of resection and complications was performed.

Results There were a total of 112 patients referred for endoscopic therapy. Of these 112 patients, 37 underwent ampullectomy and 85 patients were referred for resection of non-ampullary duodenal polyps > 10 mm.

In patients who underwent ampullectomy, 27 (73%) had a submucosal injection, whereas pancreato-duodenal stent was placed in 26 (70%) of patients. 7 (20%) patients had adjunct tissue ablation (APC). 62% of the lesions were pure ampullary, whereas 38% polyps involved the duodenum.

In the 85 patients who were referred with a non ampullary duodenal lesion, 58 (68%) underwent endoscopic mucosal resection (EMR) and 27 (32%) had knife assisted resection (KAR). Majority of the lesions (70) were found in D2 (82%).

Further characteristics have been summarized in table 1

Abstract PWE-038 Table 1

	Non ampullary duodenal resections	Ampullectomies
Number	85	37
Median age	64 years [IQR 27–87]	66 years [IQR 50–83]
Mean size	25.3 mm	21.6 mm
Diagnosis of FAP	9.4%	13.5%
En bloc resection	40%	43.2%
Median follow up	38 months	16 months
Recurrence	7%	24.3%
Bleeding	8%	5.4%
Perforation	2%	0%
Lesions >30 mm	38%	32%

All complications were managed endoscopically The majority of the recurrences were treated successfully with subsequent endoscopic resection. No procedure related mortality was noted in this cohort.

Conclusions Endoscopic resection of duodenal and ampullary lesions is a safe and effective technique for complete removal of these polyps. The risk of complications is similar in ampullary and non-ampullary resections, however, the risk of

recurrence is higher in patients with ampullary adenomas. Nevertheless, we demonstrated that all complications and most recurrences were successfully managed endoscopically.

Nutrition

Orals

OTU-27 **THE HIDDEN BURDEN OF EMERGENCY DEPARTMENT ATTENDANCES FOR LATE ENTERAL TUBE FEEDING COMPLICATIONS**

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Introduction Late complications related to enteral tube feeding are little documented in the literature. One 10 year study reports a longitudinal rate of displacement of up to 12%¹. Here we investigate the hidden burden of community enteral tube feeding on the Emergency Department (ED).

Method We undertook a retrospective review of attendances to the emergency department of the district general hospital in Wolverhampton with gastrostomy and jejunostomy tube complications. ED discharge coding was reviewed over an 18 month period to identify patients attending ED with a gastrostomy or jejunostomy tube. Electronic medical records were then reviewed to determine if the primary reason for attendance was related to the enteral feeding tube.

Results In an 18 month period 139 attendances were recorded, 56% of cases were male patients. Fifty patients came from nursing homes, 8 from residential homes, 2 from another hospital and 79 (57%) from their own homes.

One hundred and nine were completely dependent on the enteral tube for all nutrition and hydration, 8 required it for fluids only, 2 for nutrition only and 20 were not completely dependent on the enteral tube.

The type of tube prompting attendance is shown in table 1

Abstract OTU-27 Table 1

Type of enteral tube	No
PEG	46
RIG	26
PEG-J	8
Transgastric BGT	7
Jejunostomy	28
Low profile	8
BGT	16

(PEG = percutaneous endoscopic gastrostomy, RIG= radio-logically inserted gastrostomy, J= jejunostomy, BGT = balloon gastrostomy tube)

The problems causing the ED attendance are shown in table 2.

Where in hours was defined as 9–5 Monday to Friday and all other times were defined as out of hours 57 attending during standard working hours of the nutrition support team and 82 attended when the support team were not available, out of hours.