Methods This case involved a 66 year old male of Indian origin with a history of CSI, Gilbert's syndrome, urticaria, angioedema, and gallstone disease. He presented with a three week history of malaise, fever, anorexia and jaundice. His liver function tests demonstrated obstructive jaundice (bilirubin 76 $\mu\text{mol/L}$, ALT 116 $\mu\text{unit/L}$, ALP 637 $\mu\text{unit/L}$). A CT identified biliary obstruction at the liver hilum. A subsequent MRCP identified the cause of biliary obstruction to be a 23 mm gallstone impacted in the common hepatic duct. An outpatient ERCP was performed with the patient in a prone position using a therapeutic duodenoscope (Olympus TJF-240) with their body turned to the right. After the duodenoscope was navigated into the stomach, it was torqued to the left which allowed the pylorus to be identified. The duodenoscope was then navigated to the second part of the duodenum. Initially a 'short scope' position was adopted but this was found to be unstable and resulted in the duodenoscope falling back into the stomach. As a result, a 'long scope' position was adopted for the remainder of the procedure.

Results In a 'long scope' position wire guided cannulation (0.035 Boston Dreamwire) was performed. A cholangiogram confirmed the MRCP findings. After a sphincterotomy was performed (Boston Dreamtome) a 10Fr $\times$ 7 cm straight plastic stent (Boston) was inserted. The procedure was uncomplicated and the patient was discharged following ERCP; post ERCP pancreatitis was not observed. The patient's liver function tests subsequently normalised.

Conclusions A PUBMED and EMBASE literature search has identified that 10 cases of ERCP have been described in patients with CSI (Hu et al 2015, Sharma et al 2018). This case, however, is the first reported case from a hospital within the UK and indeed the first ever in which video footage has been obtained during both intubation and cannulation. As per previous reports, the patient was placed prone with the endoscopist turning 180° to the right as compared to ERCP with conventional anatomy. Despite adopting this position, we found that a 'short scope' position was unstable and cannulation was achieved after a 'long scope' position was adopted. Whilst the procedure was technically challenging it was felt to be of a similar difficulty to ERCP procedures in other altered anatomical states. We hope the video footage obtained during this procedure will help other endoscopists successfully perform ERCP when faced with a patient with CSI.

PTH-065 NEEDLE KNIFE FISTULOTOMY IN ERCP: SINGLE ENDOSCOPIST'S EXPERIENCE

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Introduction Needle knife fistulotomy (NKF) is a recognised technique used for difficult biliary cannulation.¹ Various studies have shown that early usage of the technique is safe and successful when compared to persistent standard cannulation attempts.² The decision when to turn to the needle knife however is very operator dependent. We will review the data from an experienced ERCPist to see how ones decision to opt for precut may have changed over time as well as the success and complication rates that go along with it. Then using videos of previous procedures we will discuss what criteria we

look for and the techniques we use to perform the optimum fistulotomy.

Methods We reviewed all the ERCP procedures done by an experienced endoscopist in one centre over four and a half years. We looked at the reports to find out the frequency with which NKF was performed, as well as the success and complication rates.

Abstract PTH-065 Figure 1 Precuts performed over time

Results Over 55 months, one ERCPist carried out 700 ERCP's. In 110 of those procedures, NKF was performed. The majority of cases were for choledocholithiasis and stricturing disease (66 cases and 21 cases respectively). The NKF success rate in the first attempt was 83.6% (92 of the 110 cases). 56% (10) of failed cannulation had repeat ERCP, and biliary cannulation was achieved in all. The overall success rate was 92.7%. Over the given time period, we can see a general trend for an increased ratio of needle knife procedures performed per 100 ERCP's done (figure 1). 4 cases of delayed complications were encountered in total (3 cases of post-ERCP pancreatitis and 1 case of a contained duodenal perforation).

Conclusion The increased proportion of fistulotomies over time may demonstrate more confidence in the technique, and so it is more readily considered as an option in cases of difficult access. Also, it may represent an increased awareness of which ampullas are more amenable to precut rather than conventional cannulation techniques and this is something we will go on to discuss in our video presentation.

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PTH-066 CHOLANGIOSCOPIC MANAGEMENT OF PROXIMALLY MIGRATED BILIARY STENT USING A NOVEL THROUGH THE CHOLANGIOSCOPE SNARE

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Migration of biliary stent occurs in 5–10% of cases. However, proximal migration of pigtail stents is rare.

Retrieval of these stents can be challenging and requires utilisation of various endoscopic grasping devices. With increasing use of ERCP and biliary stents this is being encountered more frequently. Most stents can be retrieved with conventional grasping devices like stent grabbers or biopsy forceps. However, some case may require the use of novel through the cholangioscope devices.

We present a 37-year-old lady who presented with choledocholithiasis and 4 conventional ERCPs were not successful in clearing the CBD stones. At spy glass cholangioscopy we discovered a proximally migrated biliary stent. This video demonstrates a novel technique to retrieve the migrated biliary stent.

PTH-067 TREATMENT OF BLUE RUBBER BLEB NEVUS SYNDROME IN A PAEDIATRIC PATIENT ASSISTED BY DOUBLE-BALLOON ENTEROSCOPE

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Introduction Blue rubber bleb nevus syndrome (BRBNS) is an extremely rare systemic vascular disorder characterised by multiple cutaneous and gastrointestinal venous malformations. Patients present with fatigue, iron deficiency anaemia (IDA) and occult or overt gastrointestinal (GI) bleeding. Patients are usually treated with conservative management including iron supplementation and blood transfusions. However, endoscopic (argon plasma coagulation, sclerotherapy, polypectomy, band ligation etc), radiological and surgical approaches are preferred for severe cases.

Aims and Methods A 7-year-old female patient with iron deficiency anaemia and multiple cutaneous lesions was diagnosed with BRBNS at a local hospital. The patient was referred to our institution for further management due to blood transfusions dependence and PR bleeding. A small bowel capsule endoscopy (SBCE) revealed two vascular lesions in the small bowel.

Results An anterograde double-balloon enteroscopy (DBE) was the performed under general anaesthesia. Two 20 mm vascular lesions were identified in the gastric body. A loop ligating device (Olympus, Tokyo, Japan) was applied around the base of each lesion then tightened and completely detached. No further vascular malformations were found in the duodenum, jejunum and proximal ileum. Although the number of units of blood transfusion decreased over the next 6 months a follow-up retrograde DBE was performed due to persistent anaemia. Six lesions were identified in the transverse colon (2), caecum (1) and distal ileum (3). Ligation loop was used for 2 colonic lesions while two ileac rubber blub lesions were treated with both ligation loop and metallic clips. Since the 2 remaining lesions were flat and floppy, loop ligation was not technically feasible. No immediate and post procedural complications (including delayed bleeding) occurred.

Conclusion DBE facilitated loop ligation appears to be a safe and minimally invasive option in patients affected by BRBNS reducing the blood transfusion dependence.

PTH-068 SPORADIC LATERALLY SPREADING NONAMPULLARY DUODENAL ADENOMAS: THE ROLE OF SALINE-IMMERSION THERAPEUTIC ENDOSCOPY

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Introduction Sporadic laterally spreading nonampullary duodenal adenomas (SLSNDA) are an uncommon incidental finding during oesophagogastroduodenoscopy. Endoscopic mucosal resection (EMR) in the duodenum is challenging due to increased risk of perforation and bleeding. Underwater EMR (UEMR) is a novel and effective endoscopic resection technique performed without submucosal injection. Saline-immersion therapeutic endoscopy (SITE) is an evolution of UEMR and saline solution is used instead of water to minimise the risk of water intoxication.

Aims and methods Our aim was to evaluate the efficacy and safety of SITE-EMR for SLSNDA via a retrospective review of SLSNDA resected by SITE-EMR at our institution from May 2017 to October 2018. Demographic, clinical, endoscopic findings and follow-up data were analysed.

Results

Nine SLSNDA (median size 25 mm) were found in eight patients (4 male, median age: 69 year-old). One was located in D1, 4 in D2 and 4 in D3. En-bloc resection was achieved in two lesions (23%) while wide-field resection was performed in seven lesions (77%). Complete resection was achieved in seven patients (87.5%). A circumferential lesion involving the whole duodenal bulb was found in one case and SITE-EMR technique was not feasible as well as other alternative endoscopic resection techniques due to severe fibrosis; the patient was therefore referred for surgery and excluded from further analysis. Histological results revealed six (75%) tubulo-villous adenomas with low-grade dysplasia and two tubular adenomas low-grade dysplasia (25%). Immediate complications including perforation and bleeding did not occur. One patient (12.5%) presented with delayed GI bleeding 24hours post procedure and was treated successfully with endoclips. Three cases (37.5%) of recurrences were identified at 3 months follow-up requiring further endoscopic treatment. No further recurrence was identified at 6 and 12 months follow-up in any patient.

Conclusion SITE-EMR of SLSNDA appears to be a safe and effective management with low recurrence rates at long term follow-up.

PTH-069 SIMULATED CASES; A TOOL TO TEACH ENDOSCOPY NON-TECHNICAL SKILLS

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Introduction There has been growing awareness of the importance of non-technical skills (NTS) in endoscopy however training in this area varies and may not be explicit in many departments. It is important that this is recognised and efforts are made to improve awareness. In the Northern Deanery the REST (regional endoscopic skills training) course has been