of stay. In other ways, for some other reasons, especially in our national government insurance, we could not perform those procedures in tertiary hospital as a routine procedure.

Methods In this retrospective study, we would evaluate, the length of stay difference between open conventional and laparoscopy cholecystectomy on calculous cholecystitis patients from January until December 2017. The length of stay after these procedures would be recorded. All patients had the same prophylactic antibiotic (2 gram of Cefazolin iv) and 1 gram Paracetamol iv twice daily. The patients who have been done the conversion to open cholecystectomy would be excluded from this study.

Results 94 calculous cholecystitis cases were evaluated in this study during 1 year period. 71 cases have been done open conventional cholecystectomy, 23 cases have been performed laparoscopy cholecystectomy. The mean length of stay on the open arm was 1.7 days, and 1.5 days for laparoscopy cholecystectomy. 3 patients on the open conventional arm had biliary pancreatitis and empyema gall bladder, and that case has a longer length of stay (3 days). There was no post-operative complication recorded.

Conclusions There was no length of stay difference between open conventional and laparoscopy cholecystectomy on calculous cholecystitis patients.

IDDF2020-ABS-0084

COMPARISON OF 1L ADJUVANT AUXILIARY PREPARATIONS WITH 2L SOLELY POLYETHYLENE GLYCOL PLUS ASCORBIC ACID REGIME FOR BOWEL CLEANING: A META-ANALYSIS OF RANDOMIZED, CONTROLLED TRIALS

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Background The effectiveness of additional usage of adjuvants for bowel preparation is still unclear. This study compared 1L polyethylene glycol plus ascorbic acid with adjuvant drug regimens (1L-PEG-AA, lower-volume) with 2L polyethylene glycol plus ascorbic acid (2L-PEG-A, low-volume) to evaluate whether the adjuvants can be used to reduce the standard dosage of purgative further.

Methods The PubMed/MEDLINE, EMBASE, Cochrane Library and Web of Science database were searched up to March 2020 for randomized controlled trials (RCTs). The primary outcome was the efficacy of bowel preparation, and the secondary outcomes were patients' tolerability and complication rate. The relative risk (RR) and mean difference (MD) with 95% confidence intervals (CI) were pooled for dichotomous and continuous variables separately. The overall quality of evidence was assessed using the GRADEpro guideline development tool.

Results Five RCTs with a total of 1013 patients were included, and the majority of patients were outpatients from different hospitals. The pooled data showed no significant difference in the adequate bowel preparation rate (89.3% versus 89.4%, RR 1, 95%CI 0.95–1.05, $I^2=47\%$) (figure 1A) as well as in the complication rate (RR for nausea 1.22, 95%CI 0.89–1.65, $I^2=49\%$; RR for bloating 0.96, 95%CI 0.73–1.28, $I^2=0\%$; RR for vomiting 0.69, 95%CI 0.32–1.50, $I^2=33\%$;

A

Abstract IDDF2020-ABS-0084 Figure 1A Forest plot on the efficacy and willingness between 1L-PEG-AA and 2L-PEG-A

B

Abstract IDDF2020-ABS-0084 Figure 1B Forest plot on the efficacy and willingness between 1L-PEG-AA and 2L-PEG-A

RR for abdominal pain 1.01, 95%CI 0.61–1.69, $I^2=0\%$). But a significantly higher willingness rate was observed in the lower-volume (85.1% versus 67.9%, RR 1.25, 95%CI 1.14–1.38, $I^2=46\%$) (figure 1B). The quality of primary outcome evidence was moderate.

Conclusions The findings of this meta-analysis revealed that 1L-PEG-AA might be a viable alternative to 2L-PEG-A, with comparable effectiveness, better patient preference, and no statistically significant adverse event occurrence.

IDDF2020-ABS-0085

UNDERWATER VERSUS CONVENTIONAL ENDOSCOPIC MUCOSAL RESECTION FOR SMALL SIZE NON-PEDUNCULATED COLORECTAL POLYPS: A RANDOMIZED CONTROLLED TRIAL

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Background Underwater endoscopic mucosal resection (UEMR) is a recently developed technique and is performed during

Abstract IDDF2020-ABS-0085 Table 1 Comparative analysis of primary outcomes

Parameter	CEMR	UEMR	P value
Intention-to-treat analysis	n=71	n=71	
Complete resection, n (%)	62(87.3)	59(83.1)	0.478 [‡]
Incomplete resection, n (%)	9(12.7)	12(16.9)	
En bloc, n (%)	65(91.5)	67(94.4)	0.512 [‡]
Piecemeal, n (%)	6(8.5)	4(5.6)	
Per-protocol analysis	n=71	n=66	
Complete resection, n (%)	62(87.3)	59(89.4)	0.706 [‡]
Incomplete resection, n (%)	9(12.7)	7(10.6)	
En bloc, n (%)	65(91.5)	62(93.9)	0.591 [‡]
Piecemeal, n (%)	6(8.5)	4(6.1)	

CEMR, conventional endoscopic mucosal resection. UEMR, underwater endoscopic mucosal resection.

[‡] Chi-square test.

water-aided colonoscopy for the treatment of colorectal polyps. The objective of this clinical trial was to evaluate the efficacy and safety of UEMR in comparison with conventional endoscopic mucosal resection (CEMR) of diminutive non-pedunculated colorectal polyps.

Methods Patients with small size, non-pedunculated colorectal polyps (4–9 mm in size) who underwent colonoscopic polypectomy were enrolled in this multicenter randomized controlled clinical trial. The patients were randomly allocated to two groups, an UEMR group and a CEMR group. Efficacy and safety were compared between groups.

Results In the intention-to-treat (ITT) analysis, the complete resection rate was 83.1% (59/71) in the UEMR group and 87.3% (62/71) in the CEMR group ($P = 0.478$). The en bloc resection rate was 94.4% (67/71) in the UEMR group and 91.5% (65/71) in the CEMR group ($P = 0.512$) (table 1). Immediate bleeding was observed in 1.4% of patients in the CEMR group (1/71) and 1.4% of patients in the UEMR group (1/71). None of the patients in the UEMR group complained of postprocedural bloody stool, whereas two patients in the CEMR group (2/71) reported this adverse event.

Conclusions Our results indicate that UEMR is safer and just as effective as CEMR for the treatment of small colorectal polyps as such, UEMR is recommended as an alternative approach to excising small and non-pedunculated colorectal adenomatous polyps.

IDDF2020-ABS-0086 TACROLIMUS, A BOON FOR ELDERLY-ONSET ULCERATIVE COLITIS!

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Background Cases of elderly-onset ulcerative colitis (UC) have been growing in number in recent years and currently account for 10–15 percent of all UC cases. While UC care is largely identical between older and younger patients, there is still little evidence of the therapeutic efficacy of tacrolimus in patients with elderly-onset UCs. Here, we detail our attempt to induce remission in a patient with elderly-onset UC using tacrolimus. Tacrolimus was used to treat a 63-year-old Indian

man with serious elderly-onset pancolitis-type UC. Medical recovery in the patient succeeded.

Methods A 67-year-old man suffered 3 days of bloody diarrhoea 11 times a day and visited a local hospital. Abdominal CT showed strong oedema in the colon. Treatment with 5-ASA and oral prednisolone at 1 mg/kg/day was started, along with complete parenteral nutrition, under the suspected UC diagnosis. However, the patient was moved to our hospital 1 week after the onset of symptoms, as the symptoms didn't change. Blood test results on admission were as follows: 10.500/cumm WBC count, 2.85 mg/dl serum CRP, and 58 mm/h ESR. Sigmoidoscopy reported acute, persistent and circumferential hemorrhage, mucosal redness, and oedema. The patient had been diagnosed with extreme pancolitis type UC. Prednisolone and 5-ASA were continued, and 0.05 mg/kg/day dose of tacrolimus was introduced. The Clinical Activity Index (CAI) had decreased from 12 to 4, 2 weeks after the initiation of tacrolimus. The dosage of prednisolone was tapered slowly, and azathioprine was started at a dosage of 50 mg; the patient was discharged on day 17 of the hospital. Colonoscopy performed 3 months after tacrolimus initiation showed a clear trend towards improvement

Results Colonoscopy performed 3 months after tacrolimus initiation showed a clear trend towards improvement. The objective findings were concordant with subjective reports of symptomatic relief. There were no major adverse events during therapy with tacrolimus.

Conclusions Tacrolimus provides some signs of effectiveness for treating elderly-onset UC. However, more thorough research is needed to assess the effectiveness and safety of this therapy in this vulnerable population.

IDDF2020-ABS-0087 TITANIUM RING CLAMP AND NYLON ROPE BY ENDOSCOPIC POLYPECTOMY IN COLORECTAL LONG-PEDICLED POLYPS

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Background To observe and compare the effects of titanium ring clamp and nylon rope by endoscopic polypectomy in colorectal long-pediced polyps.

Methods The clinical data of patients undergoing endoscopic polypectomy in our center from June 1, 2018, to May 31, 2019, were retrospectively analyzed. 40 patients with 51 long-pediced polyps in a diameter of 1.5 – 2.5 cm were enrolled in our study. 27 polyps of 23 patients (11 males and 12 females) were treated by endoscopic electric coagulation combined with nylon rope (nylon rope group). 24 polyps of 17 patients (9 males and 8 females) were treated by endoscopic electric coagulation combined with titanium ring clamp (titanium ring clamp group). Polyp sites, polyp sizes, JNET types, hospitalized days, complete resection rates, complication rates, intraoperative and delayed hemorrhage rates were collected and compared.

Results No death occurred in our study. There were also no severe complications occurred, such as perforations and serious infections. The polyp sizes were 1.9 ± 0.33 cm in the nylon rope group, while 1.7 ± 0.20 cm in the titanium ring clamp group ($P=0.02$). JNET types of polyps in the nylon rope group were 1(25.9%,n=7), 2A (59.3%,n=16) and 2B(14.8%,