IDDF2020-ABS-0187 LAPAROSCOPIC EXTRACTION OF A RAPUNZEL: SAFE AND EFFECTIVE

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Background Rapunzel syndrome is a rare manifestation of trichobezoar characterized by extension of a mass of hair across pylorus into the small bowel. Only 40 odd cases have been reported in the literature to date. Most of the Rapunzels have been treated by laparotomy and a few by laparoscopic assistance. Reports on the complete laparoscopic extraction are scarce. We report a successful laparoscopic extraction of a Rapunzel in a 17-year-old girl.

Methods A 17-year-old girl presented with a history of pain abdomen and non-bilious vomiting for a month duration. The girl was studying in a residential school, and she had an urge to pull and eat her hair. Her vital examination was normal. Her weight was 23 kg. There was a mass palpable in the epigastrium. Routine blood investigations were within normal limits. The radiological evaluation showed a non-homogenous opacity occupying the whole of the stomach, extending into the duodenum and jejunum suggestive of Rapunzel syndrome. A psychiatric evaluation revealed that she was in severe depression due to the death of her beloved one. Antidepressants were initiated and planned for surgery.

Results Under General anesthesia, she was placed in lithotomy position. A 5-mm subumbilical camera port was placed. Three 5-mm operating ports were placed in the right hypochondrium, left lumbar, and epigastric regions. A 10 cm long anterior gastrotomy was done, the Rapunzel was released from the stomach wall all around and gently delivered into an endogenously made sturdy endobag. Extra care was taken to completely extract the Rapunzel and to avoid the spillage. The subumbilical port incision was extended on either side to bring out the mouth of the endobag. A sponge holding forceps was used to remove the trichobezoar in piecemeal

Abstract IDDF2020-ABS-0187 Figure 1 Anterior gastrotomy was done (A), Rapunzel delivered into an endobag and extracted via subumbilical port site by piecemeal with the endobag acting as wound protector (B and C)

(figure 1). The patient was started on a liquid diet from the 2nd postoperative day, gradually escalated to a normal diet by 4th day, and discharged after psychiatric counseling and medications. She is on follow up for the past six months and currently asymptomatic.

Conclusions Complete extraction of a Rapunzel by laparoscopy is safe. A sturdy endobag prevents spillage and also acts as a wound protector.

IDDF2020-ABS-0190 EFFICACY OF INFLIXIMAB TREATMENT ON THE MUCOSAL HEALING OF DIFFERENT INTESTINAL SEGMENTS IN PATIENTS WITH ILEOCOLONIC CROHN'S DISEASE

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Background Mucosal healing (MH) is the key aim of the treat-to-target strategy for patients with Crohn's disease (CD). The efficacy of infliximab on MH in different ileocolonic segments is unclear. The aim of this study was to investigate endoscopic MH in different ileocolonic segments in patients with CD who received infliximab treatment.

Methods A retrospective, single-center study was performed in patients with active ileocolonic CD between January 2012 and December 2018. All patients underwent IFX treatment for at least 30 weeks. The MH of five ileocolonic segments was assessed by the Simple Endoscopic Score for CD (SES-CD) at baseline, week 14 and week 30. The SES-CD scores were analyzed by a mixed-effects model after the confounding factors were corrected.

Results A total of 101 eligible patients were included. The baseline endoscopic severity was similar across segments. At week 30, the greatest changes in SES-CD ulcer size and ulcerated surface were -94.29% and -94.32% both in the transverse colon ($P < 0.0001$), and the smallest changes were -67.88% and -69.67% both in the terminal ileum ($P < 0.0001$) compared with the changes in the other segments. Stenosis mainly presented in the right colon (12/29, 41.38%). The change in SES-CD stenosis was -6.25% in the right colon at week 30 compared with -71.88% at week 14 ($P = 0.0030$). At week 30, the transverse colon achieved the highest rate of complete MH (CMH) with 81.2%, and the lowest CMH rate occurred in the terminal ileum with 45.6%.

Conclusions Ileocolonic segments in Crohn's disease presented different endoscopic MH during IFX treatment. The transverse colon showed the highest MH rate, whereas the right colon had poor improvement in stenosis even underwent long-term IFX therapy.

IDDF2020-ABS-0191 MULTIMODALITY MANAGEMENT OF BORDERLINE ADVANCED UNCINATE CARCINOMA AND POSTOPERATIVE GASTROJEJUNOSTOMY FISTULA

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Abstract IDDF2020-ABS-0191 Figure 1 Tripple phase CT of postneoadjuvant chemotherapy carcinomal uncinete

Abstract IDDF2020-ABS-0191 Figure 2 CECT showing afferent loop OG GJ obstruction

Abstract IDDF2020-ABS-0191 Figure 3 Infant feeding tube inserted percutaneously being seen endoscopically at GJ site

Abstract IDDF2020-ABS-0191 Figure 4 Recovered patient after 1.5 yrs of follow up

Methods Borderline advanced malignancy patient underwent diagnostic workup and was found to have adenocarcinoma uncinata. He underwent palliative double bypass and NACT. Post-NACT reassessment was done, which showed a resectable uncinata mass with the dilated pancreatic duct. Curative resection -Whipple's pancreaticoduodenectomy was done. Biopsy showed -complete response.

The postsurgery-controlled pancreatic fistula was managed conservatively, but afferent loop of GJ and leakage developed which was treated initially with prolonged conservative treatment. After the failure of conservative TT it was operated and adhesions lysed with jejunojunal bypass was done. Still patient had 10 ml leakage from drain site pancreaticojejunostomy or gastrojejunostomy leak. Again conservative TTT was done but failed. Fistula was located by percutaneous tube and fibrin glue injection was done to heal the fistula tract which succeeded, but later again, 5 ml occasional discharge lead to exploration and fistula finally healed. The patient remained in follow up to 2.5 yrs since diagnosis and 1.5 yrs since the curative surgery, without any recurrence.

Results The patient remained disease-free for 1.5 yrs post curative surgery and 2.5 yrs since diagnosis.

The gastrojejunula healed after multiple interventions.

Conclusions The multispecialty approach gives the best results in borderline advanced uncinata malignancy

Persistence leads to the cure of any GI surgical issues in patients

Prolonged survival can be expected in curative surgery of post-NACT carcinoma uncinata

A complete response can be seen in uncinata malignancy cases.

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UNDIFFERENTIATED-TYPE-PREDOMINANT MIXED-TYPE IS MORE AGGRESSIVE THAN PURE UNDIFFERENTIATED-TYPE IN EARLY GASTRIC CANCER: A META-ANALYSIS

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Background Previous studies show that Differentiated-type-predominant Mixed-type(MD) Early Gastric Cancer(EGC) shows more aggressive behavior than Pure Differentiated-type(PD) EGC. However, the biological behavior of Undifferentiated-type-predominant Mixed-type(MU) EGC and Pure Undifferentiated-type(PU) EGC are controversial. The aims of this meta-analysis were to compare the biological behaviour between MU EGC and PU EGC.

Methods We systematically searched PubMed and EmBase for relevant studies published up to June 2020. Eligible data were extracted, the pooled results were expressed with odds ratios (ORs) and 95% confidence intervals (95% CIs) using Stata software, version 15.1.

Results In total, 8 studies were included in this analysis. MU EGC had a significantly higher lymph node metastasis(LNM) risk (OR, 2.66; 95% CI, 2.24–3.18), submucosal invasion risk (OR, 2.44; 95% CI, 1.55–3.84), and lymphovascular invasion risk (OR, 2.66; 95% CI, 2.08–3.41) compared with PU EGC. Otherwise, stratified by country, a significantly higher lymph node metastasis(LNM) risk (OR, 2.56; 95%

CI, 2.15–3.05), submucosal invasion risk (OR, 3.72; 95% CI, 1.08–12.78), and lymphovascular invasion risk (OR, 2.77; 95% CI, 2.14–3.58) correlative to MU EGC were found in Japan studies.

Conclusions Our study identifies MU EGC had an increased risk of submucosal invasion, lymphovascular invasion and LNM compared with PU EGC, which indicated that we should pay more attention to patients with MU EGC in clinical management.

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TIMING OF ENDOSCOPY FOR ACUTE UPPER GASTROINTESTINAL BLEEDING: A TERRITORY-WIDE COHORT STUDY

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Background Whilst it is commonly recommended that patients presenting with acute upper gastrointestinal bleeding (AUGIB) should receive endoscopic evaluation within 24 hours, the optimal timing is yet to be established. We aimed to assess, for AUGIB patients, whether endoscopy timing after hospital admission would significantly affect clinical outcomes.

Methods We conducted a retrospective, territory-wide, cohort study with clinical data extracted from the Hong Kong Hospital Authority (HA) Clinical Data Analysis and Reporting System (CDARS). Patients of age 18 and above that (a) presented with AUGIB to the public hospital between 2013–2019 and (b) received therapeutic endoscopy within 48 hours (n = 6,474) were recruited.

Patients were classified into 3 groups based on endoscopic timing after admission: urgent (t ≤ 6), early (6 < t ≤ 24) and late (24 < t ≤ 48). Important baseline characteristics (e.g. blood tests and comorbidities) were balanced with inverse probability of treatment weighting (IPTW). After balancing, the 30-day all-cause mortality, 30-day repeated therapeutic endoscopy rate, 30-day ICU admission rate and other endpoints were compared. We hypothesised that, amongst the three groups, early timing would be associated with the best clinical outcomes. Subgroup analysis was performed based on comorbidity burden and aetiology of bleeding. Sensitivity analysis was performed.

Results With IPTW, differences in patient characteristics across 3 groups were well balanced. Results showed that urgent (n = 1,008) and late endoscopy (n = 1,601) had worse outcomes compared to early endoscopy (n = 3,865), with higher 30-day mortality, repeat endoscopy rates and ICU admission rates.

Conclusions Compared to urgent and late endoscopy, early endoscopy timing was significantly associated with superior outcomes. This supports the notion that AUGIB patients should receive endoscopy within 24 hours, but also emphasises the importance of adequate resuscitation, medical optimisation and pharmacotherapy before rushing patients to endoscopy.