0.64) and sulfonylurea (MD: -14.21, CI: -22.86 to -5.56). SGLT2i showed the greatest reduction in BMI, being superior to sulfonylurea (MD: -1.67, CI: -3.09 to -0.25) and standard of care (MD: 3.45, CI: 1.24 to 5.66). SGLT2i showed the greatest reduction of LDL and TG and the greatest increase of HDL.

Conclusions SGLT2i, GLP-1RA and PPAR γ agonists are viable choices for the management of NAFLD in diabetic patients. SGLT2i was found to be most efficacious for fibrosis and BMI reduction, GLP-1RA for steatosis reduction and PPAR γ agonists for lipid modulation and should be considered over sulfonylurea for second-line therapy.

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RETROSPECTIVE ANALYSIS OF CHARACTERISTICS, INDICATIONS AND OUTCOMES OF ERCP IN A TERTIARY REFERRAL CENTER OF SAUDI ARABIA

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Background Endoscopic Retrograde Cholangiopancreatography (ERCP) is an advanced endoscopic procedure that is an essential tool in the management of pancreaticobiliary diseases. In the Arab world, there is limited data available on the indications and outcomes of ERCP. Therefore, we aimed to report the characteristics of patients, indications, and outcomes of ERCP from a tertiary referral center in Saudi Arabia.

Methods We retrospectively looked at ERCP procedures done at a tertiary referral center covering the western region of Saudi Arabia from August 2018 till July 2020. Data were collected from the hospital's electronic patient record and endoscopy database.

Results Of 1001 ERCP's performed, full data was available on 712 procedures on 581 patients that were included in the final analysis. Mean age was 53.1. 404 (56.7%) were female. All ERCPs were performed by certified consultants, with therapeutic intention. Sphincterotomy was performed in 563/581 (96.9%) patients who underwent first-ever ERCP. The commonest indication of ERCP was confirmed or suspected choledocholithiasis (52.6%), followed by replacement or removal of a biliary stent (15.7%), 55 (7.7%) for suspected ascending cholangitis, 54 (7.5%) for severe acute biliary pancreatitis, and 15 (2%) for suspected sphincter of Oddi dysfunction. The commonest finding among all patients was choledocholithiasis in 57.9%, debris in 15.2%, and biliary stricture in 14.8%. The commonest complication was pancreatitis 22/712 (3.1%) followed by post-sphincterotomy bleeding 16/712 (2.2%) and perforation 9/712 (1.2). Bleeding was controlled by endoscopic intervention in 4/16 (25%) and 1/16 (6.2%) patient underwent surgery. 2/712 (0.28%) patients had procedure-related mortality, one secondary to post-procedure pulmonary embolism and the other because of complicated perforation. The deeper CBD cannulation rate was 98.2% (570/581).

Conclusions Our study results revealed that ERCP performed in Saudi Arabia has similar indications and findings as compared to international literature. ERCP is successful in achieving the therapeutic objective with complication rates consistent with published literature.

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SAFETY OF CONTINUING ANTICOAGULATION DURING ENDOSCOPIC VARICEAL LIGATION IN CIRRHOSIS PATIENTS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background Endoscopic variceal ligation (EVL) is a common procedure for primary and secondary prevention of variceal bleeding in cirrhosis patients. As portal vein thrombosis is associated with a higher risk of variceal bleeding and decompensation in cirrhosis patients, anticoagulation may be considered in these patients. However, it is uncertain if continuing anticoagulation during EVL may significantly increase the risk of bleeding. To address this gap, we performed a systematic review and meta-analysis to evaluate the safety of continuing anticoagulation during EVL. The primary outcome was the bleeding risk following EVL. Secondary outcomes were mortality following EVL and length of stay (LOS).

Methods We performed a systematic search of 4 electronic databases (PubMed/MEDLINE, EMBASE, Cochrane library, and ClinicalTrials.gov) up to May 21, 2021 using both free text and MeSH terms. We included all studies that reported the 4-week rebleeding rate in cirrhosis patients during EVL, regardless of study design, language, publication types or status. The pooled relative risk (RR), mean difference (MD) and 95% confidence interval (95%CI) of study outcomes were estimated using Review Manager in a random-effect model.

Results A total of six studies (5,102 subjects, 1,028 received anticoagulation) fulfilled our inclusion criteria. The mean (standard deviation) MELD and Child-Pugh score were 18 (5.5) and 7 (1.6), respectively. Follow-up duration ranged from 6 to 196 weeks. The overall pooled risk of bleeding and mortality was 8.2% (95%CI: 6.6%-10.0%) and 8.6% (95%CI: 4.2%-15.3%), respectively. Mean number of bands deployed per session was similar between the anticoagulation and control group. Continuation of anticoagulants during EVL was not associated with a higher pooled risk of bleeding (RR: 0.90, 95%CI: 0.71-1.15, $I^2 = 0\%$) and mortality (RR: 1.16, 95%CI: 0.22-6.19) following EVL. However, continuing anticoagulation was associated with a shorter LOS (3.9 days, 95% CI: -7.35 to -0.48 days, $I^2 = 0\%$). All studies had a low risk of bias except for one.

Conclusions In cirrhosis patients undergoing EVL, continuing anticoagulation was safe without a significant increase in bleeding and mortality.

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SURGICAL TREATMENT FOR NON-COLORECTAL NON-NEUROENDOCRINE LIVER METASTASES: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background Liver-only metastasis from primary tumor elsewhere is common. Hepatectomy for colorectal or neuroendocrine liver metastases have favourable survival outcomes and