Patients were 11.4±7.9 years post-RYGB and regained 35±22.8% of maximal weight loss. 30/41 (75%) underwent traditional endoscopic suturing and 11 (27%) underwent modified ESD with fistula resection prior to endoscopic suturing. Part I: GGF size was 11.0±4.0 mm with 56% being a large GGF (≥10 mm). On average, 3.4±2.2 stitches were placed. The suture patterns included an interrupted suture pattern (49%), running suture pattern (32%) and a combination of interrupted, running and mattress suture patterns (19%). Technical success rate of 100%. There were no adverse events. Follow-up EGD or UGIS was available in 29/41 patients (71%). Overall clinical success was achieved in 9/29 patients (31%). Part II: Compared to the traditional method, modified ESD-based endoscopic suturing was associated with a greater success rate of GGF closure (56% vs 20%, p<0.05). When stratified by GGF size, the ESD method was more effective at GGF closure than the APC method for both small and large GGF (small: 75% vs 14%; large: 50% vs 0%, p<0.05). Conclusion: Combining modified ESD and fistula tract resection with endoscopic suturing appears to be safe and effective at treating GGF and may enhance clinical outcomes.

Figure 1. Endoscopic suturing for gastrogastric fistula closure (A) Gastrogastric fistula (B) Modified endoscopic submucosal dissection (ESD) prior to endoscopic suturing (C) Argon plasma coagulation (APC) prior to endoscopic suturing (D) Endoscopic suturing for gastrogastric fistula closure.

532 CLINICAL VALUES OF DENTAL FLOSS TRACTION ASSISTANCE IN ENDOSCOPIC FULL-THICKNESS RESECTION FOR SUBMUCOSAL TUMORS ORIGINATING FROM THE MUSCULARIS PROPRIA LAYER IN THE GASTRIC FUNDUS

Qiang Shi, Yunshi Zhong*, Li-Qing Yao, Pinghong Zhou Endoscopy Center, Zhongshan Hospital, Fudan University, Shanghai, 200032, China, Shanghai, Shanghai, China

Background and Aims: With the development and maturation of endoscopic resection, endoscopic full-thickness resection (EFTR) derived from endoscopic submucosal dissection (ESD) is gradually accepted and promoted to treat submucosal tumors (SMTs) originating from muscularis propria (MP) layers. However, there are some difficulties when EFTR is applied in the treatment of muscularis-propria lesions in gastric lesions. This study intends to explore whether EFTR can be more simple, safe and effective with the traction assistance of dental floss. Methods: From January to December in 2016, the clinical data of patients (trial group) with lesions from MP in gastric fundus undergoing EFTR with traction assistance of dental floss was matched with trial group according to tumor size by one to one from January to December in 2016, the clinical data of patients (trial group) with lesions from MP in gastric fundus undergoing EFTR with traction assistance of dental floss was matched with control group. EFTR traction could better reveal the blood vessels or endoscopic traction could help expose the tumor boundary, so that the operation field was clearer to simplify the operation process and significantly reduce the procedure time. Second, in the course of surgery, EFTR-assisted dental floss traction could better reveal the blood vessels or find bleeding blood vessels for prevention and early treatment of bleeding. Third, when the tumor was completely resected, dental floss could also prevent the tumors from falling into the abdominal cavity and help to remove the excised tumors.

Figure. The dental floss traction-assisted endoscopic full-thickness resection for muscularis propria tumors in gastric fundus.

533 NO INCREASED RISK OF POST-PROCEDURAL UNPLANNED HOSPITAL ENCOUNTERS FOLLOWING AMBULATORY COLONOSCOPY IN PATIENTS WITH CIRRHOSIS: A POPULATION-LEVEL, COHORT-CONTROLLED STUDY.

Robert J. Huang*, Monique T. Barakat, Shai Friedland, Subhas Banerjee Stanford University School of Medicine, Stanford, CA

Background/Aims: Colonoscopy is the most commonly performed endoscopic procedure in the United States. Many patients with cirrhosis may benefit from colorectal cancer screening, but the safety of colonoscopy in this cohort has not been previously studied on a population level. Methods: We used the databases of the Healthcare Cost and Utilization Project (HCUP) from the states of California (years 2009-2011), New York (2011-2013), and Florida (2012-2014) to identify all outpatient colonoscopies in patients with cirrhosis. From the databases, we selected cirrhotic patients who did not undergo colonoscopy during the observation period and assigned them a synthetic index date to serve as a cirrhotic control. Separately, we selected non-cirrhotic patients who did undergo colonoscopy during the observation period to serve as a colonoscopy control. The primary endpoint was the composite rate of unplanned hospital admission or emergency department visit, defined as unplanned hospital encounters (UHE), in seven days following procedure or synthetic date. Secondary endpoints were UHE rates at 14 days, as well as the rate of specific adverse events related to either colonoscopy (gastrointestinal [GI] bleeding, perforation, cardiovascular [CV] event) or cirrhosis (infection, spontaneous bacterial peritonitis [SBP], hepatic encephalopathy [HE]). We identified the degree of cirrhotic severity by capturing cirrhotic sequelea utilizing a six-month retrospective observation period. Results: 3,719 cirrhotic patients who underwent colonoscopy (colonoscopy/cirrhosis), 4,000 cirrhotic controls, and 4,000 non-cirrhotic colonoscopy controls were included for analysis. The colonoscopy/cirrhosis cohort had slightly lower rates of known esophageal varices (EV), and total number of cirrhotic sequelea compared to cirrhosis controls (Table 1). The colonoscopy/cirrhosis cohort had a higher rate of snare polypectomy performance, despite fewer procedures being performed for a screening or surveillance indication compared to colonoscopy controls (Table 1). In an additive risk model, performance of colonoscopy in cirrhosis was not associated with a higher risk of UHE at either seven or 14 days. At seven days, there was a slight increase in risk for bleeding (attributable risk 0.6%, CI 0.3 to 0.8%), however, this excess risk receded by 14 days. There was no excess risk for perforation, infection, SBP, HE, or CV event at either seven or 14 days.

Conclusions: Outpatient colonoscopy does not lead to increased attributable risk for
学霸图书馆
www.xuebalib.com

本文献由“学霸图书馆-文献云下载”收集自网络，仅供学习交流使用。

学霸图书馆（www.xuebalib.com）是一个“整合众多图书馆数据库资源，提供一站式文献检索和下载服务”的24小时在线不限IP图书馆。

图书馆致力于便利、促进学习与科研，提供最强文献下载服务。

图书馆导航：
图书馆首页 文献云下载 图书馆入口 外文数据库大全 疑难文献辅助工具