

Background Endoscopic retrograde cholangiopancreatography (ERCP) has become an invaluable procedure in the management of pancreaticobiliary disorders. Selective cannulation of the common bile duct (CBD) is a prerequisite for successful therapeutic ERCP; however, it may fail in 5–20% of cases even in experienced endoscopists. Precut sphincterotomy is a technique done to gain access to the CBD when standard methods have failed. Needle-knife precutting is the most widely used method and has been reported to improve cannulation success rates. Some studies have demonstrated high rates of complications associated with this technique; while recent data confirmed that the impact of precut sphincterotomy depends on timing.

Methods We conducted this meta-analysis to investigate whether early precut sphincterotomy is associated with increased risk of procedure-related adverse events (PRAE) compared with persistent cannulation. We also aim to determine the optimal timing of precut to prevent post-ERCP pancreatitis (PEP). A systematic search on four online databases was done. Studies were validated using the Cochrane risk-of-bias assessment tool and the Newcastle-Ottawa scale. Results were analyzed using the Cochrane Review Manager v5.3. The primary endpoints were the overall incidence of PEP and optimal time for precut sphincterotomy. Secondary outcomes were overall PRAE rate and success rate of biliary cannulation.

Results Nine RCTs and 1 cohort (1,571 of 14,017 screened patients) were included in this meta-analysis. Pooled incidence showed a statistically significant decreased rates of PEP with early precut sphincterotomy (4.3%) compared with persistent cannulation (7.5%) (RR 0.60; 95% CI 0.39–0.92). Using a random-effects model, test for heterogeneity showed an $I^2 = 0\%$ and $\text{Chi}^2 = 5.97$. Subgroup analysis stratified based on the timing of precut showed that performing precut sphincterotomy at 5–10 minutes from initial cannulation has significantly lower rates of PEP (RR 0.50; 95% CI 0.26–0.94).

Conclusions This meta-analysis suggests that compared with persistent cannulation, early precut sphincterotomy was associated with a significantly decreased risk of developing PEP. In addition, subgroup analysis showed that performing precut after 5 minutes, but not exceeding 10 minutes after failed biliary cannulation, has the benefit of having 50% less risk of developing PEP (Figure 1)

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PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG): AN IMPORTANT ENTERAL FEEDING ROUTE

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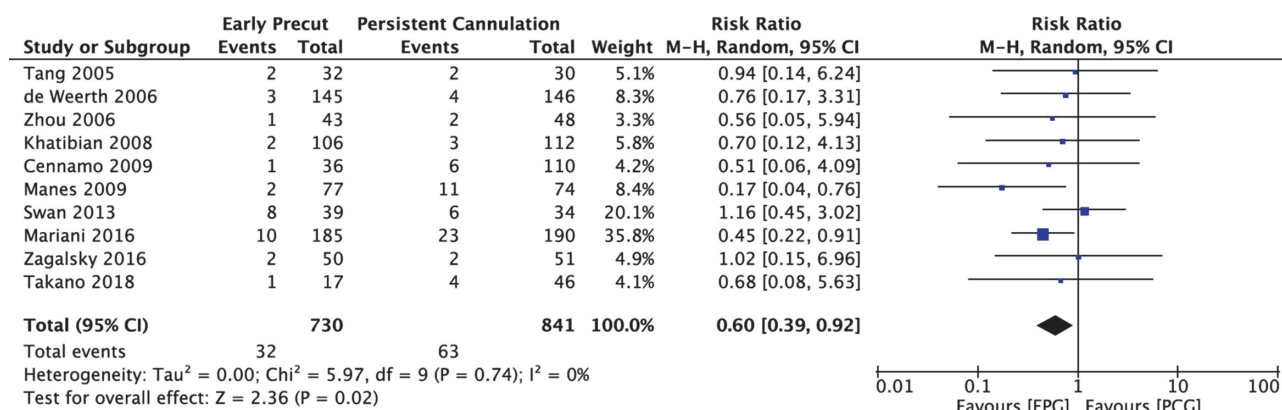
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Background The modern point of view on enteral nutrition has shifted towards an earlier individual consideration of additional supplementary feeding via Percutaneous Endoscopic Gastrostomy (PEG) tube when special nutritional support is required. Here we aim to assess the efficacy and safety of this technique.

Methods Appropriately selected patients requiring prolonged enteral feeding (>4 weeks), underwent PEG placement after overnight fasting, by pull technique using 24F tube under monitored anesthesia and sterile conditions. Prophylactic intravenous antibiotic was administered and antiplatelet/anticoagulant drugs were withheld prior to the procedure as per standard guidelines. Relatives were taught about feed preparation, administration technique, care of tube and gradual encouragement of oral feed with signs of recovery.

Results During the assessment period of 5 years, a total of 236 patients underwent PEG placement with a technical success rate of 100%. 193(82%) patients were men and the average age was 58 years. Neurological indications were the most common (75%) which included diffuse axonal injury and intracranial hemorrhage following road traffic accident, massive stroke, neurodegenerative disorders, bulbar palsy; followed by head & neck malignancies (10%), hypoxic ischemic injury (10%) in survivors of cardiac arrest and 5% included various medical conditions requiring nutritional support.

Most commonly reported complication was PEG site pain & infection 12(5%). Gastrostomy site leakage 3(1.2%), abdominal wall bleeding occurred in 5(2%) patients. Endoscopy & anesthesia related complications (desaturation, hypotension, transient arrhythmias, and aspiration) occurred in 5 (2%) patients. Delayed intra-abdominal bleeding and buried bumper syndrome were noted in 2(0.8%) patients each. Asymptomatic pneumoperitoneum was found in 28(12%) patients. All these were managed conservatively and none required tube removal.



Abstract IDDF2020-ABS-0101 Figure 1 Forest plot for the incidence of pep

34(14%) patients required tube replacement either due to tube damage or accidental removal. After clinical improvement and demonstration of normal swallow study, 168(71%) patients had their tube removed after an average duration of 120 days. 68(29%) of patients died due to non-PEG related complications during follow up.

Conclusions PEG is a safe and highly efficient feeding method in carefully selected patients with a low rate of complications and a high level of acceptance. It helps in the improvement of nutritional status and quality of life.

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DETAILED DIAGNOSTIC CLASSIFICATION FOR CROHN'S DISEASE CASES WITH ANAL FISTULA BASED ON ETIOLOGY BY EXAMINATION UNDER ANESTHESIA

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Background According to the etiological classification, anal fistulas in Crohn's disease (CD) which derived from CD lesions are secondary lesions (s.l.). We classified s.l. as follows: In case of presence of clear CD lesion at the primary orifice (p.o.), it was classified as s.l.CD lesion (+), whereas in the absence of CD lesion, it was classified as a s.l.CD lesion (-).

To examine the prognosis of patients that primary orifice (p.o.) is not on the dentate line and no clear CD lesion.

Methods 17 patients who have been followed up for >5 years post-the first examination under anesthesia (EUA) were included in the study.

To determine the therapeutic effect, we defined cases with closed fistula as *cured*, those in whom drain can be removed, but symptoms may exist as *improved*, those in whom drains cannot be removed as *unchanged*, and those in whom rectal amputation was required as *worsened*. The target cases were divided into s.l.CD lesion (+), and s.l.CD lesion (-), and the prognosis was examined.

Results Nine and eight patients showed s.l.CD lesion (+), and s.l.CD lesion (-), respectively. The results are shown in the table 1. Among s.l. cases, more patients with CD lesion (-) underwent biotreatment before EUA than those with s.l.CD lesion (+); furthermore, biotreatment was started earlier after EUA in the former than in the latter. Nevertheless, the prognosis of CD lesion (-) cases tended to be poor.

Abstract IDDF2020-ABS-0105 Table 1

	s.l.CDI(+) (n=9)	s.l.CDI(-) (n=8)
Age: (Mean±SD) (years)	32.4±14.5	31.6±9.2
sex: M/F	5/4	6/2
Anal fistula type: simple/complex	0/9	0/8
anal or rectal stenosis at EUA: yes/no	1/8	2/6
Pre EUA bio treatment: yes/no	3/6	4/4
Duration from EUA to start of bio treatment (mean±SD) (month)	13.3±22.7	9.3±6.1
Post-EUA observation period (Mean±SD) (month)	99±18.3	95.3±9.6
Therapeutic effect:cured/improved/unchanged/worse	4/1/4/0	2/1/4/1

Conclusions Based on the findings, the prognosis of patients that p.o. is not on the dentate line and no clear CD lesion is poor.

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DOES FRAILTY PREDICT POSTOPERATIVE OUTCOMES IN GERIATRIC PATIENTS RECEIVING SURGERY FOR COLORECTAL CANCER? A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background Surgery remains the mainstay of colorectal cancer (CRC) and substantially reduces cancer-related morbidity and mortality. Frailty is defined as a biological syndrome, reflecting a state of impaired homeostatic reserve and predisposing to rehospitalisations and deaths in older individuals. Preoperative assessment for frailty is critically important in risk stratification and clinical decision-making. In this systematic review and meta-analysis, we aimed to quantitatively summarise the effect of frailty on postoperative outcomes in geriatric patients receiving surgery for CRC.

Methods A systematic literature search was conducted in MEDLINE, Cochrane and EMBASE from inception to 30 April 2020. Fully published articles reporting risk estimate (s) of frailty on postoperative complication(s), readmission and/or mortality in patients aged ≥ 65 years who received surgery for CRC were eligible for qualitative and quantitative analyses.

Results Across 10 articles of 9 unique studies (n = 69332) that were eventually included in the systematic review and meta-analysis, overall prevalence of frailty was 23.0% (95% CI: 11–43%, $I^2 = 100\%$). Odds ratios (ORs) on overall and severe postoperative complications were respectively increased by 2.36- (95% CI: 1.66–3.35, $P < 0.01$; $I^2 = 12\%$) and 2.35-fold (95% CI: 1.30–4.27, $P < 0.01$; $I^2 = 72\%$) in frail patients compared to non-frail counterparts. On pooled analysis, frailty was significantly associated with an increased risk of postoperative readmission (OR:1.91; 95% CI: 1.35–2.70, $P < 0.01$; $I^2 = 6\%$). Whilst a significantly higher risk of frailty on mortality during 12 months after CRC surgery was observed (OR: 5.52; 95% CI: 4.40–6.92, $P < 0.01$; $I^2 = 89\%$), the summary OR on 30-day/inpatient mortality crossed the null line (OR: 1.65; 95% CI: 0.56–4.93, $P = 0.37$; $I^2 = 55\%$). Funnel plot and Duval-Tweedie's trim and fill test did not reveal significant publication bias.

Conclusions In the studies reviewed, frailty appeared to be associated with increased risks for postoperative complications, readmission and mortality during 12 months in patients aged ≥ 65 years who received surgery for CRC. Nevertheless, no significant association between frailty and 30-day/inpatient mortality was observed.