

Guidelines for the Submission of Abstracts

- The abstract should relate to original, unpublished work and must not have been previously presented at any major meeting.
- Abstracts must consist of four paragraphs, entitled: **Aims, Methods, Results, Conclusions.**
- Abstracts are to be submitted as text and tables only (i.e. no figures, graphs or diagrams).
- The text must fit within the abstract template. The maximum word count is 400 words.
- No more than a maximum of eight authors should be listed.
- The category which best describes the subject of your work, from the list of topics on the previous page, should be indicated either benign or malignant.
- Duplicate submissions will be disqualified.
- After the submission deadline has closed, absolutely no changes can be made to the abstract

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Endosonography-guided biliary drainage following failed ERCP: Experience from a UK tertiary referral centre 2016-2017.

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Aims

Percutaneous transhepatic biliary drainage (PTBD) is associated with significant morbidity and prolonged hospital stays. [1,2] Endosonography-guided biliary drainage (EUS-BD) is an alternative to PTBD when endoscopic retrograde cholangiopancreatography (ERCP) biliary decompression has failed. EUS-BD transmural or facilitated transpapillary drainage is possible via the intrahepatic or extrahepatic bile ducts. The aims of this study were to review the technical success and adverse events with EUS-BD procedures performed at a tertiary care referral centre.

Methods

Data were prospectively recorded on EUS-BD procedures performed at a single centre from 1st January 2016 to 15th September 2017. Procedures were performed by two experienced endoscopists trained in interventional EUS and ERCP. Recorded variables were technical success, adverse events, length of stay, 30-day re-admission rate and all-cause mortality.

Results

17 patients (8 male) were included (table 1). Indications for drainage were choledocholithiasis (n=7) and malignant obstruction (pancreatic cancer, n = 6; cholangiocarcinoma, n = 1; diffuse large B-cell lymphoma, n = 1; duodenal adenocarcinoma, n = 1; and papillary carcinoma, n = 1). Reasons for failed ERCP were obscured intradiverticular ampulla (n = 7), duodenal stenosis with inaccessible papilla (n = 6; malignant, n = 5; Crohn's, n = 1), and failed cannulation (tumour infiltration of ampulla, n = 2; tumour ingrowth of existing metal stent, n = 1; malignant distal biliary stricture, n = 1). The route of attempted biliary drainage was choledochoduodenostomy in 9, EUS-guided rendezvous in 7, and hepaticogastrostomy

in 1. Overall technical success was achieved in 16 (94%), with one patient requiring PTBD. 16 cases (94%) were achieved under conscious sedation with midazolam and fentanyl. There was one instance of stent maldeployment, salvaged with fully covered metal stent placement over preserved wire access, and one TIA related to discontinuation of anticoagulation. 6 cases were performed as elective, out-patient procedures. Median length of stay post procedure was 5 days (range 2 – 80 days) for inpatient cases. There were no re-admissions or deaths within 30 days.

Conclusions

This study adds to the existing literature supporting EUS-BD as an effective and safe alternative to PTBD after failed ERCP, which can be performed under conscious sedation, often in the outpatient setting. Our technical success rate is comparable to published series.[3] Adverse event rates compared favourably with accepted rates from PTBD.[1] Experience and improved instruments should reduce procedural time and further prospective randomised studies are needed to compare outcomes for percutaneous versus EUS guided drainage.

References

- 1 Covey AM, Brown KT. Percutaneous Transhepatic Biliary Drainage. *Tech Vasc Interv Radiol* 2008;**11**:14–20. doi:10.1053/j.tvir.2008.05.003
- 2 Winick AB, Waybill PN, Venbrux AC. Complications of percutaneous transhepatic biliary interventions. *Tech. Vasc. Interv. Radiol.* 2001;**4**:200–6. doi:10.1016/S1089-2516(01)90026-5
- 3 Prichard D, Byrne MF. Endoscopic ultrasound guided biliary and pancreatic duct interventions. *World J Gastrointest Endosc* 2014;**6**:513–24. doi:10.4253/wjge.v6.i11.513