

OE-0333 (YI-0003) Clinical efficacy and safety of EUS-guided gallbladder drainage replacement of percutaneous drainage: A multicenter retrospective study

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Background and Aims: Percutaneous transhepatic gallbladder drainage (PTGBD) is widely used for patients with acute cholecystitis. There is little data on the efficacy and safety of endoscopic ultrasound-guided gallbladder drainage (EUS-GBD) replacement of PTGBD in patients who cannot undergo cholecystectomy. **Methods:** This multicenter retrospective study in Japan reviewed records of all patients who underwent EUS-GBD to replace PTGBD between January 2010 and December 2017. Outcomes evaluated included technical success, defined as successful stent placement between the gastrointestinal lumen and the gallbladder; clinical success, defined as subsequent removal of the percutaneous catheter; adverse events; and stent patency. **Results:** An EUS-GBD procedure was performed in 21 patients (14 women, mean age 77.5 ± 8.0 years) to replace PTGBD that had been instituted for acute cholecystitis ($n = 19$) or obstructive jaundice ($n = 2$). Technical success was achieved in 19 (90.5%). The median period from PTGBD placement to EUS-GBD was 11 days (range, 6–68 days). The mean procedure time was 19.5 ± 5.1 min. No early adverse events were observed. There were 3 late adverse events, distal stent migration in 2 cases, and stent occlusion causing recurrent cholecystitis in 1. Reintervention was required in 2 patients. The percutaneous catheter was removed after EUS-GBD in 17 patients at a median of 7 days (range, 2–20 days). The duration of stent patency was 139 days (range, 8–664 days). **Conclusion:** When ongoing gallbladder drainage is required, conversion from PTGBD to EUS-GBD is a feasible, effective, and safe technique in patients who cannot undergo cholecystectomy.

Keywords: cholecystitis, endoscopic ultrasound, EUS-GBD, EUS-guided gallbladder drainage, interventional EUS

OE-0401 (YI-0004) Six years experience of enhanced recovery after colorectal surgery (ERAS) protocol in a resource poor setting in South Asia—What have we done to overcome the limitations

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Background and Aims: ERAS aims for speedy postoperative recovery. Though evidence based, ERAS practice is yet at inception in Sri Lanka. All steps are not possible due to resource limitations. **Methods:** Elective colorectal cancer resections performed by single surgeon at University Surgical Unit of Colombo South Teaching Hospital from 2011 to 2016 were analyzed. ERAS protocol was applied with following modifications; early admission, CVP guided fluid management due to unavailability of goal directed fluid therapy, epidural analgesia due to no patient-controlled analgesia devices, postoperative 24 hours ICU care due to unavailability of HDU establish normal diet before discharge due to lack of community health follow-up system. **Results:** Hundred and twelve patients had colonic resections; laparoscopy 71.4%. Mean age was 59.6 years. Male : female was 1.08:1. Preoperative sub-cutaneous enoxaparin was given to all patients. Morning clean enema was given for left colonic resections. No bowel reparation in right colonic resections. Median days of postoperative care were progressive mobilization-day 01, oral fluids-day 01, catheter removal-day 02, normal diet-day 03.70% opened bowel on day 04. Median days of ICU stay-02. Nasogastric intubation was done in 40% and median day of removal was 02. Four (4.3%) patients who underwent laparoscopic low anterior resections had anastomosis leaks. All of them have had neo-adjuvant therapy. Three of them needed reopening and other one was managed conservatively. 17% surgical site infections were reported with significant difference between open and laparoscopic resections ($P = 0.008$). Median days of hospital stay were 6 (range 3–21 days) without a deference between groups. 30 day mortality was zero. **Conclusion:** ERAS protocol with minor modifications was well tolerated by our cohort. Favorable outcomes of our center are compatible with published data. Therefore, ERAS protocol would be a safe and feasible alternative to traditional practice of colorectal surgery even in resource poor setting.

Keywords: ERAS, modified, resource poor setting