

was applied resulting in bleeding cessation. She had self limiting post-procedural abdominal pain but no evidence of perforation on imaging. No clinical rebleeding occurred during the next 6 weeks, although she continued to require 2-weekly transfusions as before for her chronic anaemia. Patient 3 – a 72 year old man with advanced hepatocellular carcinoma, cirrhosis due to hemochromatosis, and transfusion dependent anaemia despite beta-blockers, presented with fresh rectal bleeding. Flexible sigmoidoscopy demonstrated severe portal hypertensive colopathy with active bleeding. Hemospray was applied and hemostasis achieved. He had no complications and no further rectal bleeding by 6 weeks. There was evidence of reduced transfusion requirements during this 6 week period. Patient 4 – a 66 year old lady with decompensated alcohol related cirrhosis presented with abdominal pain and melena. Emergency gastroscopy revealed active bleeding from severe proximal PHG. Hemospray was applied leading to hemostasis. Following the procedure the patient developed increasing abdominal pain and imaging showed evidence of free peritoneal air. She was deemed unfit for surgical intervention due to her co-morbidities and died of sepsis secondary to perforated abdominal viscus 4 days following the procedure.

Conclusion Hemospray appears to achieve hemostasis in acute non-variceal portal hypertensive bleeding. Further data are required on the outcome and safety of Hemospray use in this condition.

Disclosure of Interest None Declared.

PWE-055 ENDOSCOPIC ULTRASOUND GUIDED RADIOFREQUENCY ABLATION (EUS-RFA) FOR PANCREATIC DUCTAL ADENOCARCINOMA

doi:10.1136/gutjnl-2013-304907.344

¹M Pai, ²J Yang, ³X Zhang, ³Z Jin, ³D Wang, ⁴H Senturk, ⁵S Lakhtakia, ⁵D N Reddy, ⁶M Kahaleh, ^{1,7}N Habib, ⁸W R Brugge. ¹HPB Unit, Hammersmith Hospital, Imperial College London, London, UK; ²GI Department, Hangzhou First People's Hospital, Hangzhou; ³Digestive Endoscopy Center, Changhai Hospital, Second Military Medical University, Shanghai, China; ⁴Bezm-i Alem University, Istanbul, Turkey; ⁵Asian Institute of Gastroenterology, Hyderabad, India; ⁶Division of Gastroenterology & Hepatology, Department of Medicine, Weill Cornell Medical College, New York; 10065, NY, United States; ⁷EMcision Limited, London, UK; ⁸Massachusetts General Hospital, Harvard Medical School, Boston; 02114, MA, United States

Introduction The five year survival for pancreatic ductal adenocarcinoma (PDAC) is less than 5% in spite of the advances in management of cancers in the last few decades. Even though surgical resection remains the only potentially curative treatment for PDAC, only 10–20% of patients are candidates for pancreatic resection with almost 50% of patients having distant spread of tumour and approximately one-third manifesting locally advanced disease. Kahaleh and colleagues have demonstrated that EUS guided RF ablation (EUS-RFA) of the pancreatic head using Habib EUS-RFA catheter (Emcision Ltd, UK) was well tolerated in 5 Yucatan pigs and with minimal pancreatitis (1). The aim of this report is to outline the feasibility, safety, complications and early results of EUS-RFA using Habib catheter in patients with inoperable PDAC.

Methods Seven patients underwent EUS-RFA of PDAC. A novel monopolar radiofrequency (RF) catheter (1.2 mm Habib EUS-RFA catheter, Emcision Ltd, London) was placed through a 19 or 22 gauge fine needle aspiration (FNA) needle after FNA was performed.

Results Seven patients had EUS-RFA of PDAC with a median age of 69 (range 50 – 77) years. There were 3 female and 4 male patients. Five patients had PDAC in the head of pancreas whilst two had in the body of pancreas. RF was applied at 5 watts, 10 watts and 15 watts in an incremental manner in 1, 3 and 3 patients respectively. The median number of applications were 3 (range 2 – 4) and each application was 90 seconds. The EUS-RFA was completed in all patients. The mean size was 35.2mm and the post procedure imaging in 3–6 months showed decrease in size of the lesion in two

patients, whilst the lesions were unchanged in the rest of the patients. There were no early complications like injury or perforation of duodenal or gastric wall, bleeding or severe pancreatitis. All patients stayed overnight after the procedure for observation and four were discharged next day and there were no readmissions post procedure due to pain. One patient had mild pancreatitis which settled with conservative management and was discharged 3 days post procedure.

Conclusion EUS-RFA of PDAC with a novel monopolar RF probe was well tolerated in 7 patients. The initial results suggest that the procedure is technically relatively easy and safe

Disclosure of Interest M. Pai: None Declared, J. Yang: None Declared, X. Zhang: None Declared, Z. Jin: None Declared, D. Wang: None Declared, H. Senturk: None Declared, S. Lakhtakia: None Declared, D. N. Reddy: None Declared, M. Kahaleh: None Declared, N. Habib Shareholder of: EMcision Limited, London, United Kingdom, Conflict with: Director, EMcision Limited, London, United Kingdom, W. Brugge: None Declared.

REFERENCE

1. Gaidhane M *et al.* Endoscopic Ultrasound-Guided Radiofrequency Ablation (EUS-RFA) of the Pancreas in a Porcine Model. *Gastroenterol Res Pract.* 2012; 431451.

PWE-056 CANCER IS THE LEADING CAUSE OF HOSPITAL DEATH IN 30 DAY MORTALITY AUDIT FOLLOWING ENDOSCOPY

doi:10.1136/gutjnl-2013-304907.345

¹M Kasi, ¹S P Dunlop. ¹Gastroenterology, Derriford Hospital, Plymouth NHS Trust, Plymouth, UK

Introduction Mortality post endoscopy is a quality standard for all endoscopy units. Many of the published 30 day mortality studies relate specifically to those presenting with gastro-intestinal bleeding or following a therapeutic procedure, rather than for any indication or after any endoscopic procedure.

Methods We reviewed all hospital deaths occurring within 30 days following any endoscopic procedure in 12 months from 1 January 2011 to 31 December 2011, at Derriford Hospital. Data was available from Clinical coding by linking the endoscopy database with the death registry. All patients' case notes were analysed and data collected including patient demographics, indications for the procedure, type of procedure, immediate post procedure complications and cause of death.

Results There were 13310 procedures performed (gastroscopy 6224; colonoscopy 4660; flexible sigmoidoscopy 1920; ERCP 348; other procedure 158). 146 patients died within 30 days of their endoscopy (all cause mortality 1.0%). Of these, 118 patients died in hospital (81%) and 28 patients died within the community (19%). 35/118 (30%) of hospital patients died within 7 days of the procedure. Cancer was the leading cause of hospital death, accounting for 35/118 (30%); GI Cancer accounted for 24/35 (69%) and Non GI Cancer 11/35 (31%). Other causes were pneumonia 22/118 (19%); upper GI bleeding 8/118 (7%); vascular complications 16/118 (14%). All deaths from upper GI bleeding occurred within 7 days and 12/16 (75%) deaths from vascular complications occurred after 7 days. 30 day all cause mortality rates for each procedure were: colonoscopy 0.7%; ERCP 2.2%; flexible sigmoidoscopy 0.9%; upper GI endoscopy 2%; others 1.6%. Two patients had perforated distal bowel after having had flexible sigmoidoscopy (procedure related death, 2/13,283; 0.015% or 1.5 in 10,000). There were no other procedure related deaths. Eight patients died on the same day of their procedure due to uncontrolled bleeding (n = 3), acute kidney injury (n = 1), multi-organ failure following ERCP for cholangitis (n = 1), respiratory failure (n = 2) and acute ischaemia of stomach (n = 1). There were no sedation related complications nor use of reversal agents.

Conclusion Deaths within 30 days following an endoscopic procedure are most likely associated with cancer or pneumonia with