ISW26-311-01 (1010)

OUTCOMES AND PROGNOSTIC FACTORS IN OLIGOMETASTATIC ESOPHAGEAL CANCER PATIENTS UNDERGOING CURATIVE-INTENT TREATMENT

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Introduction:
Oligometastatic esophageal cancer (OEC) represents an intermediate stage between localized and widespread disease. Currently, curative-intent multimodal treatments are being trialled, though the patients likely to benefit, and ideal treatment regimens, remain unknown. We describe the oligometastatic experience of a high-volume esophageal centre with focus on identifying potentially favourable prognostic factors.

Material and Method:
Patients with OEC who underwent curative-intent esophagectomy 2007-2024 were identified from a prospectively-maintained database. Adenocarcinomas (ADC) and squamous cell carcinomas (SCC) were included; oligometastatic disease was defined by the OMEC criteria. Patients found to have oligometastases at esophagectomy, and those with metachronous oligometastases, were excluded. Descriptive statistics were used.

Results:
38 patients met inclusion criteria. Most tumors were adenocarcinomas (92%), predominantly junctional (92%). Metastatic site: non-regional lymph nodes (61%), liver (13%), lung (11%), bone (11%), limited peritoneal (3%) and brain (2%). Perioperative taxane-based chemotherapy and neoadjuvant chemoradiation were used in ADC and SCC respectively, with additional biomarker-directed therapies in nine patients. 25 patients (66%) underwent metastasis-directed therapy, most commonly surgical resection at esophagectomy (n=23). One underwent surgery and radiotherapy to a bone metastasis pre-esophagectomy, and one had intra-operative liver ablation. No metastectomy-specific treatment complications or readmissions were observed within 30 days. Median survival was 23 months (IQR 9.25-77.75) overall, with 30 months (IQR 9.75-29) for non-regional lymph node metastasis and 16 months (IQR 9.25-27) for non-nodal metastases.

Conclusion:
Curative-intent treatment for OEC is feasible and safe. Treatment of non-regional lymph node metastases may confer a favourable prognosis over other sites. Prospective multicentre studies will further inform optimal patient selection and treatment strategies.

ISW26-311-02 (0754)

A PROSPECTIVE OBSERVATIONAL STUDY TO DETERMINE THE PREDICTIVE VALUE OF MODIFIED ALVARADO SCORE TO DIAGNOSE APPENDICITIS AND SEVERITY OF ACUTE APPENDICITIS

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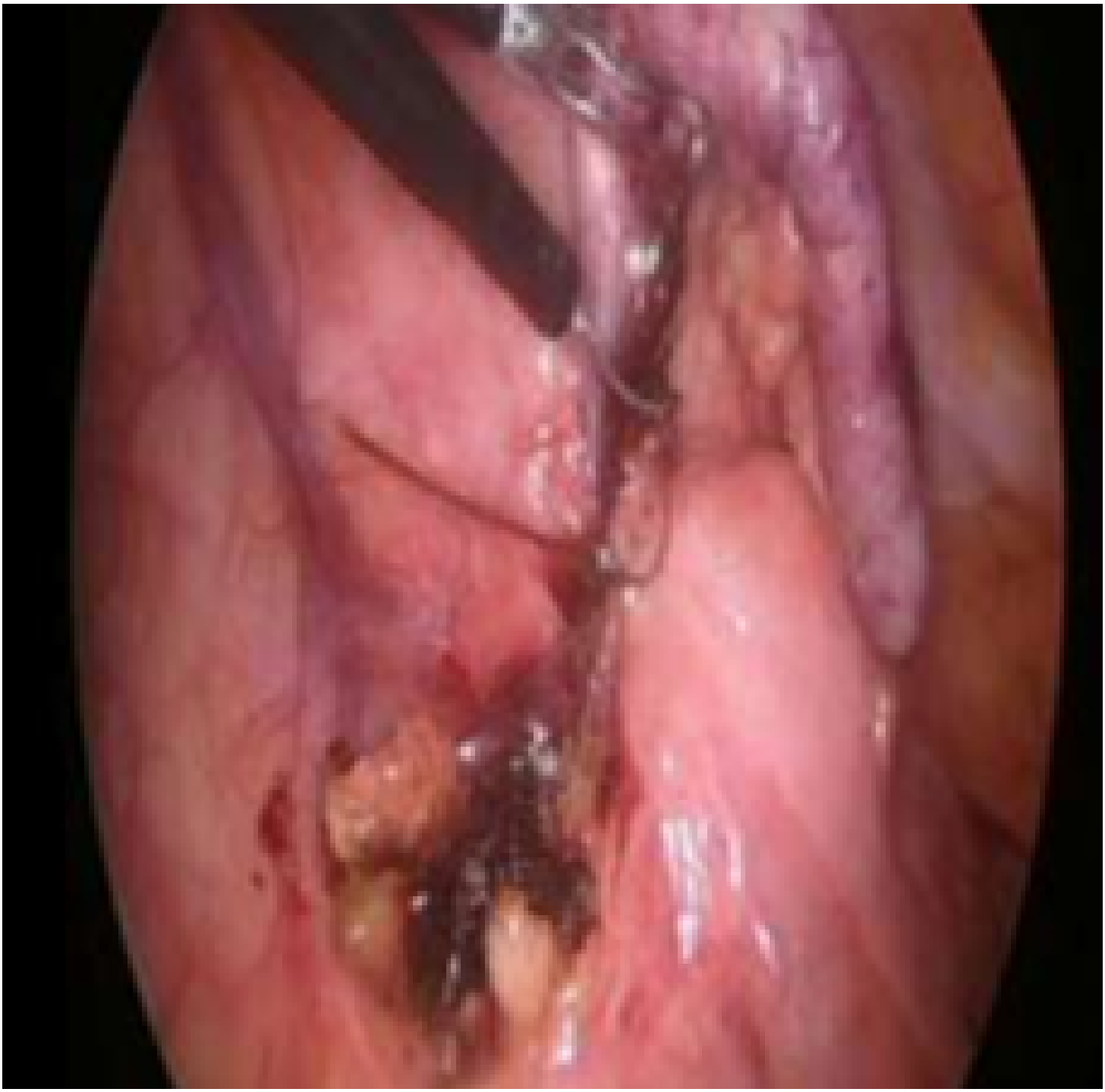
Introduction:
Appendicitis is a prevalent cause of abdominal pain, further requiring surgery, with a lifetime risk of about 7% (1). The symptoms of appendicitis can mimic other abdominal conditions, with variation of pathology in different patients .On the basis of clinical features and laboratory investigations, patients can be categorized into those who may be requiring immediate surgery, and those who do not. The Modified Alvarado Score (MAS) presents as a reliable tool to diagnose appendicitis and categorize such patients based on a set of clinical features and laboratory investigations.

Material and Method:
Prospective Observational study conducted at a tertiary care centre with 100 consecutive patients included the study .Exclusion /Inclusion criteria were applied. All the patients suspected to have appendicitis were based on Modified Alvarado score . Accordingly patients were divided into two groups A and B .Group A patients had a MAS of <7 and group B patients had a MAS of 7 and above .All 100 patients were admitted and underwent routine investigations. They were followed up for a period of 6 months – 1 year.

Results:
Common age group was 18-30 years. Migratory right iliac fossa pain in 93%, rebound tenderness in 37% , leucocytosis in 47%.When 90% underwent surgery 10% were successfully managed conservatively. Final histopathology proved acute appendicitis in 61.1%.

Conclusion:
A MAS of 7 and above 100% correlated to have appendictis on histopathology. Hence appendectomy in them can be undertaken at the earliest while those with MAS score of less than 7 can have a diagnostic laparoscopy.



ISW26-311-03 (0815)

THELDENIYA TECHNIQUE OF ENDOSCOPIC THERMO-ABLATION (TETA) FOR ESOPHAGEAL CANCER

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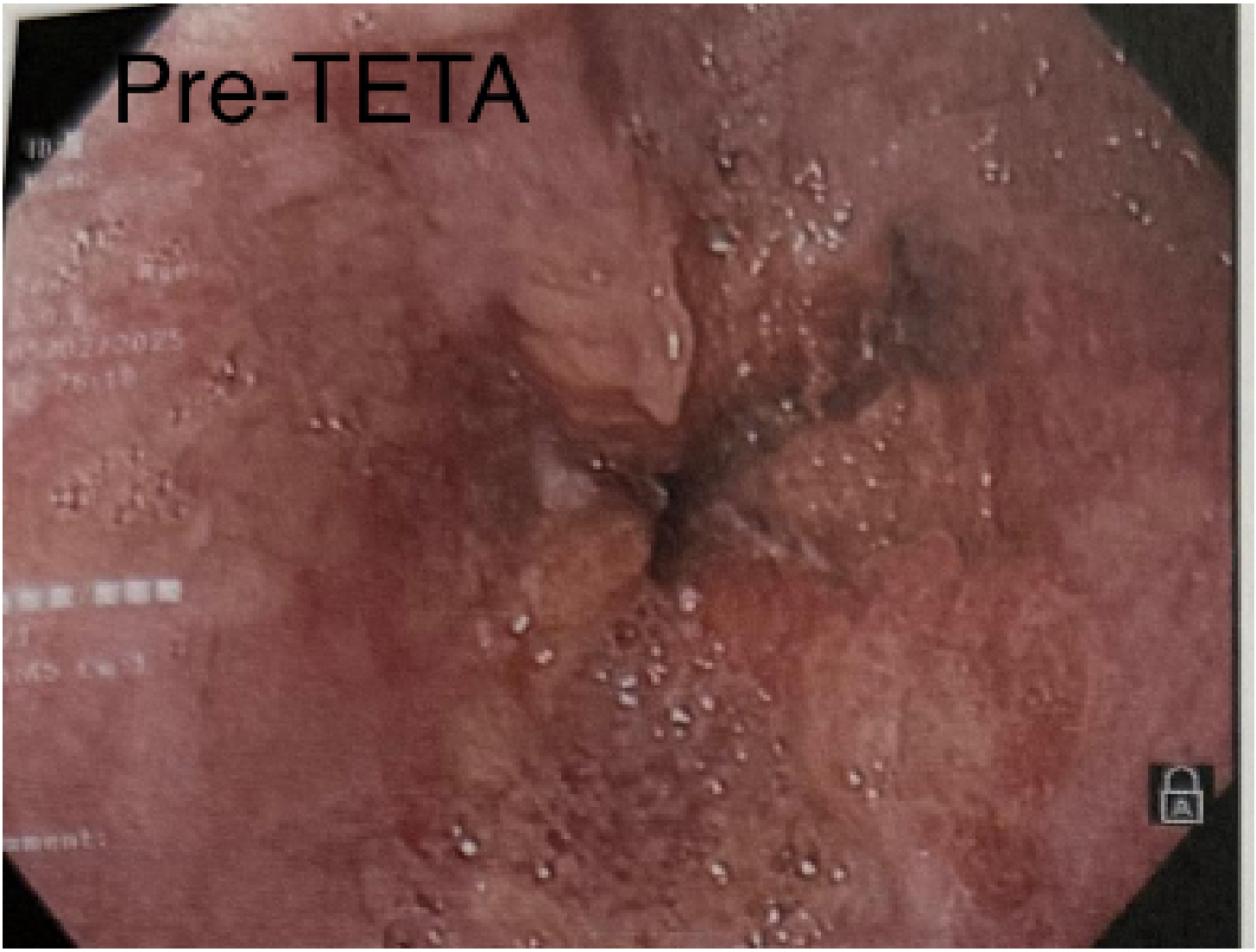
Introduction:
This new technique was devised to alleviate dysphagia in a) patients on palliation who are not amenable to stents due to very tight stricture b) patients who refuses surgery and other oncologic treatments c) patients in the work up, awaiting surgery

Material and Method:
Malignant tissues were ablated using the endoscopic hot biopsy forceps keeping diathermy in SoftCoag 90watt settings. Channel is coagulated through the obstructing tumor. All patients were scored as per Functional Oral Intake scale (FIOS), pre-TETA and post-TETA. FIOS score 1-7, 1-total dysphagia. 7-no dysphagia, Patients who were on palliation were stented using covered stents after achieving adequate channel diameter

Results:
From July/2024 to July/2025 fourteen (14) patients underwent TETA. 11 on palliative pathway and 03 on pre-op work-up. All patients climbed at least two points in FIOS scale after TETA One patient remarkably climbed from 01 to 07 (i.e. from total dysphagia to no dysphagia at all). No patient had any esophageal perforation. Two patients underwent laparo-thoracoscopic esophagectomy (both without neo-adjuvant chemo-radiation as decided in MDT). Interestingly one patient had surgical specimen histology negative for malignancy, possibly pointing to TETA having a therapeutic value as well. This particular result if supported by further evaluations would be a possible breakthrough in the management of esophageal cancer.

Conclusion:
TETA achieved good relief from dysphagia both in therapeutic and palliative settings in patients who were not amenable to esophageal stenting. There are early indications towards possible therapeutic value of TETA, which needs further evaluation.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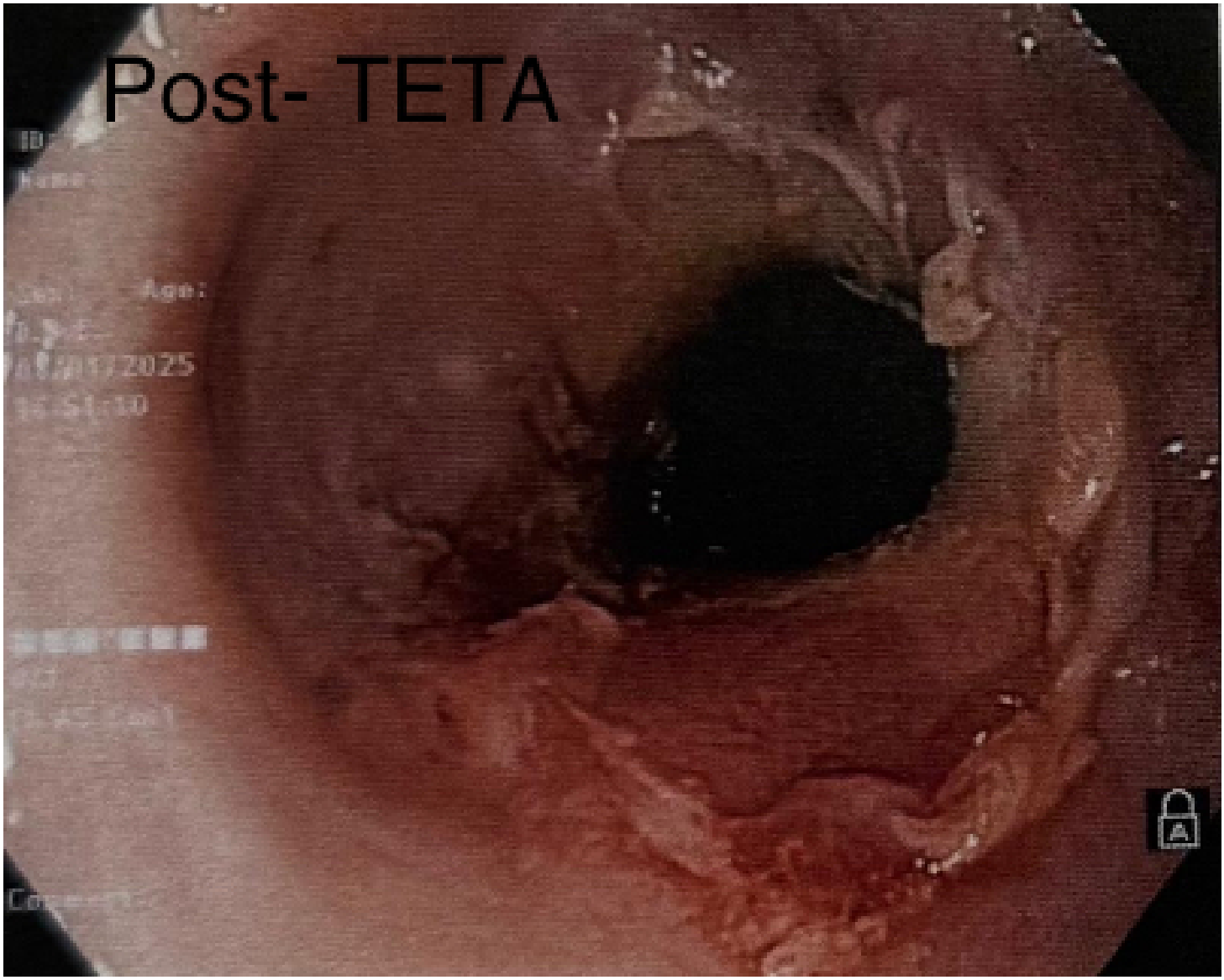
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ISW26-311-04 (0391)

BARIATRIC SURGERY: HEMORRHAGIC VS THROMBOEMBOLIC COMPLICATIONS — TOWARDS A BALANCED STRATEGY

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Introduction:
Bariatric surgery is associated with a substantial risk of both venous thromboembolism (VTE) and hemorrhagic complications. Inadequate thromboprophylaxis may lead to fatal embolic events, while excessive anticoagulation increases the risk of bleeding, particularly in the early postoperative period. Balancing efficacy and safety remains a key issue in metabolic surgery.

Material and Method:
We analyzed data from 450 patients who underwent sleeve gastrectomy or Roux-en-Y gastric bypass. The risk of venous thromboembolism was assessed using the classic Caprini scale and a modified Caprini-B scale proposed by our team, including weight, D-dimer index, and visceral fat area. Risk factors for bleeding included age, hypertension, coagulopathy, and liver or kidney dysfunction. Cases of venous thromboembolism and bleeding were recorded within 30 days after surgery, as well as the timing of their occurrence and association with risk models.

Results:
The Caprini-B model showed better predictive performance for VTE (AUC 0.81 vs. 0.69). Early hemorrhagic events (within 1–3 days) occurred in up to 3.8% of patients; late bleeding (day 4–30) occurred in 1.7%. Notably, 79% of all hemorrhages developed within 72 hours post-surgery. Risk stratification using both models allowed us to identify four patient groups: low VTE/low bleeding, high VTE/low bleeding, low VTE/high bleeding, and high VTE/high bleeding, enabling a tailored prophylactic algorithm.

Conclusion:
Integrating Caprini-B and bleeding risk parameters offers a promising approach to individualized prophylaxis after bariatric surgery. This model may enhance safety and guide dosing and duration of anticoagulation. Prospective validation is warranted.

ISW26-311-06 (0437)

BILIARY OBSTRUCTION DUE TO CLOTS, A NEW POST-ERCP COMPLICATION

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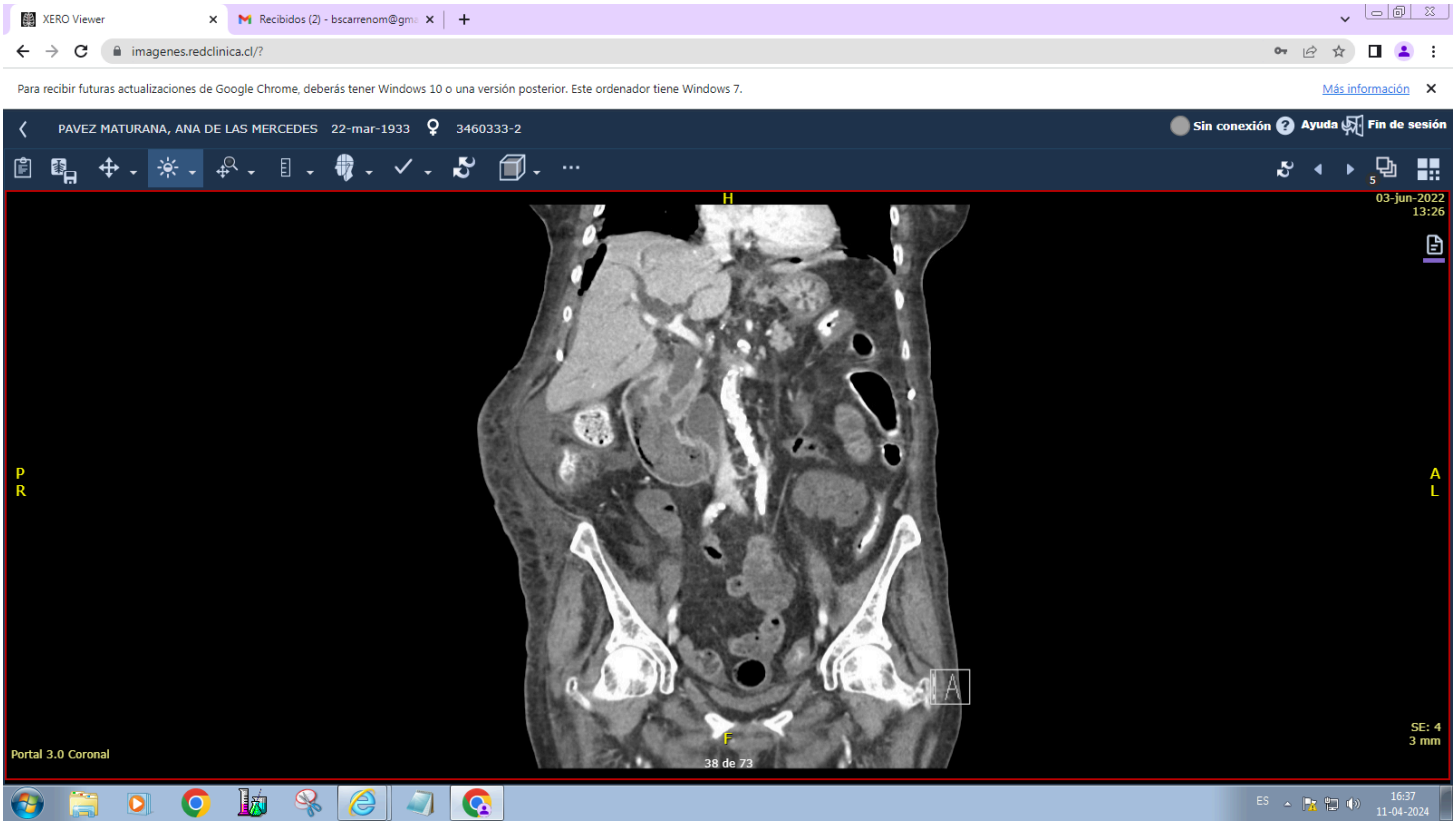
Introduction:
Endoscopic retrograde cholangiopancreatography (ERCP) is a minimally invasive procedure used in the diagnosis and treatment of biliopancreatic pathologies. Although generally safe, it has a complication rate of 5% to 10% (pancreatitis, cholangitis, intraluminal bleeding, perforation) and a mortality rate of 0.1% to 1%. Bile duct obstruction by post-ERCP clots is rare. Aim: To describe the clinical presentation, management, and outcomes of five patients who developed this complication.

Material and Method:
We conducted a retrospective descriptive study of five consecutive patients who developed biliary obstruction due to clots following ERCP, performed as part of the management of acute cholecystitis and choledocholithiasis. Data were obtained from institutional medical records.

Results:
Four women and one man (aged 19 to 89 years) underwent cholecystectomy using the rendez-vous technique and papillotomy with stone extraction. The interval between ERCP and symptom onset—including abdominal pain and cholestatic liver function test abnormalities—ranged from 24 to 96 hours. Imaging (MR or CT) revealed biliary dilation with an obstructive clot. All patients required repeat ERCP for clot removal; one required biliary stent placement. One patient developed severe acute pancreatitis and died of multi-organ failure. Another experienced recurrent hemobilia, requiring angiographic intervention and surgical sphincteroplasty to control bleeding. The overall mortality rate was 20%.

Conclusion:
Biliary obstruction due to post-ERCP clots is a rare but potentially life-threatening complication that warrants early suspicion. MRCP and endoscopy facilitate prompt diagnosis and treatment. This entity should be recognized and incorporated into the post-ERCP complication management algorithm.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Para recibir futuras actualizaciones de Google Chrome, deberás tener Windows 10 o una versión posterior. Este ordenador tiene Windows 7.
Más información
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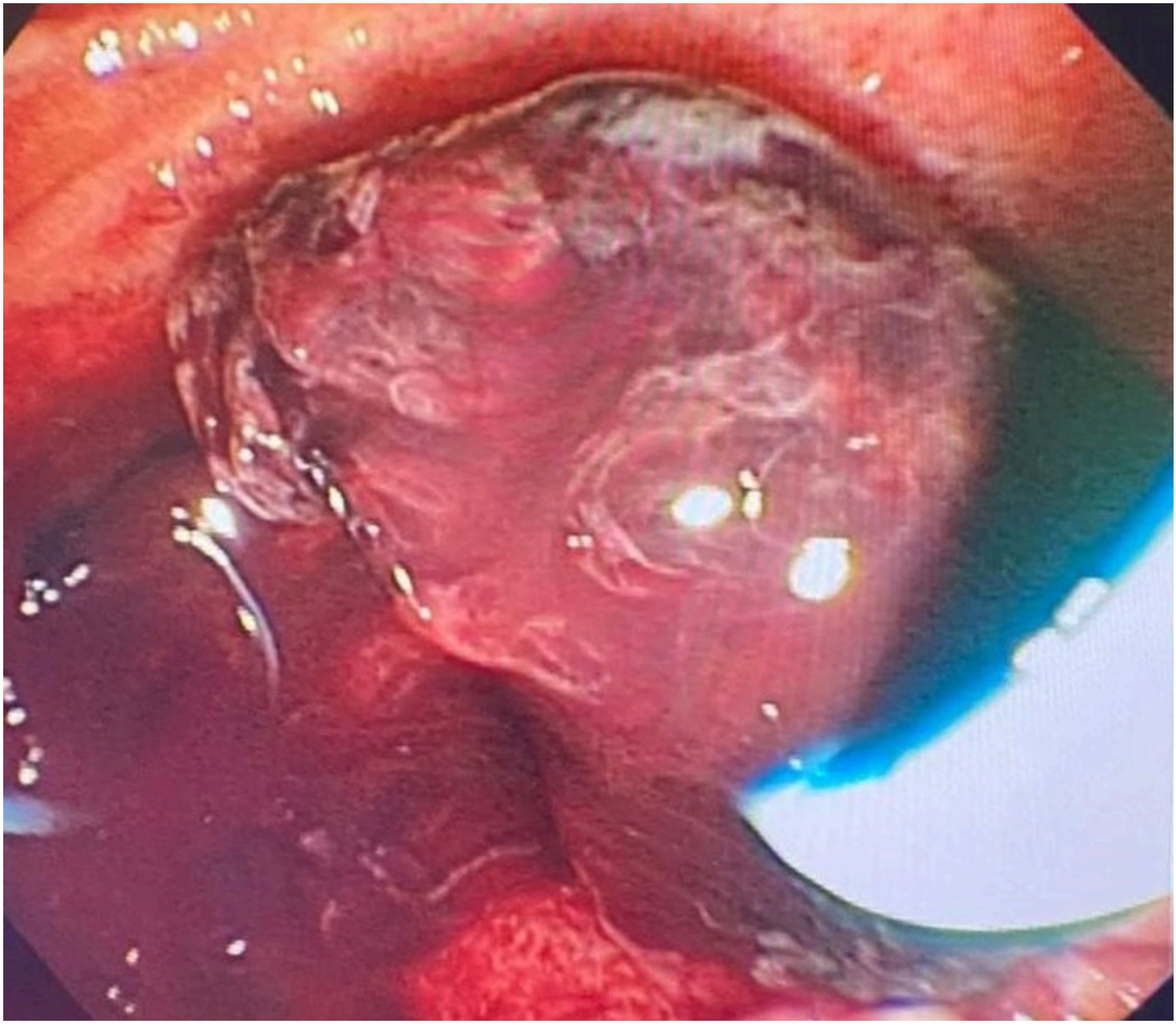

ISW26-311-07 (0803)

IS TUMOR ULCERATION AN INDEPENDENT RISK FACTOR IN GASTROINTESTINAL STROMA TUMORS

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Introduction:
Gastrointestinal Stromal Tumors are rare, though representing the most common mesenchymal tumors of the GI-Tract. Surgical Treatment still represents the basis of the multimodal treatment modalities in these patients and offers the only curative option of cure. Lastly many clinical and paraclinical factors have been evaluated in these tumors to estimate prognosis, while mucosal ulceration has not been evaluated to this day.

Material and Method:
From 195 patients, who have been operated between 2000 and 2022, demographic as well as clinicopathologic data and also informations about surgical and medical treatment (mainly imatinib) were collected and surveillance was analyzed. Survival data were calculated.

Results:
Surgery was performed in 112 men and 83 women with an average age of 64.7 years at time of operation. Primary GIST tumors were localized in the esophagus (3), stomach (127), duodenum (11), small bowel (41), large bowel and rectum (13). Average tumor diameter was 7.0 cm. In our patients we observed 86 tumors with mucosal ulceration whereas 107 tumors showed no ulceration. 5-years-survival rate was 85% in nonulcerated tumors and 74% in ulcerated GISTs (log Rank Test, p= 0.041). Risk groups (none, very low, low risk) demonstrated a significant higher 5-years-survival rate in comparison to the moderate/high risk group (88% versus 72%, p=0,046).

Conclusion:
Conclusion: Our data demonstrate that besides known and established risk factors mucosal ulceration of the primary tumor may be an independent risk factor for prognosis in GIST.