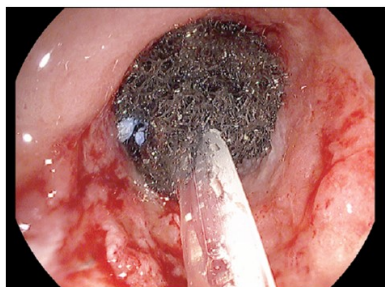


following anastomotic leakage after total mesorectal excision (TME). This system promotes healing through vacuum creation, removal of fluids and edema, infection control, local increase of blood flow and granulation tissue formation.

**Material and methods:** Between November 2012 and January 2016 five patients (M/F=1:4) with a median age of 71 years (range 65–86) who underwent TME for cancer were treated with Endosponge<sup>®</sup> system combined with different axillary endoscopic techniques for the management of anastomotic leakage. The system consists of a cylindrical polyurethane sponge (400 to 600 micron pores) of 7 cm in length, which can be cut to fit the size of the abscess cavity. The sponge is connected to a drain tube in a constant negative pressure applied through a Redyrob Trans Plus<sup>®</sup> bottle. All patients had loop-ileostomy and none presented signs of sepsis. The Endosponge<sup>®</sup> system was placed endoscopically. In all cases, after first deployment, a sterile foam dressing from negative pressure wound therapy kit was used tailoring its size to better fill the abscess cavity. Device changes were performed every 5–7 days according to the size of the cavity and the amount of secretions produced. Case by case vacuum-therapy was combined with Argon Plasma Coagulation treatment, OTSC placement, fibrin glue injection and/or endoscopic placement of other surgical devices (Spongostan<sup>®</sup>, Vycril<sup>®</sup> mesh, Promogran<sup>®</sup>).

**Results:** There was no mortality. The amount of secretions was related to the initial size and the degree of contamination of the abscess cavity. Antibiotic therapy was discontinued after an average of 21 days (range 14–32 days). Complete healing was achieved in all patients (100%) in a median of 82 days (30 to 148) in all patients with good functional results. A median number of 7 sponge replacements were carried out (range 3–14).



**Conclusions:** In our experience therapy with Endosponge<sup>®</sup> combined with different ancillary endoscopic techniques is safe and effective. Its efficacy is directly related to the time elapsed between diagnosis and first treatment. Moreover, according to our experience, it is pivotal to tailor the size of the endosponge and the concomitant use of the different ancillary techniques to enhance the success rate.

#### P.12.13

##### ADVANTAGES OF TRANSNASAL ESOPHAGOGASTRODUODENOSCOPY IN PREOPERATIVE EVALUATION OF PATIENTS UNDERGOING BARIATRIC SURGERY

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**Background and aim:** Upper gastrointestinal endoscopic evaluation represents an important step of the preoperative study for bariatric surgery. Obese patients are at high risk for airway complications during esophagogastroduodenoscopy (EGD). A safer alternative is transnasal EGD. We describe our experience with a series of patients evaluated using this technique.

**Material and methods:** All patients undergoing preoperative transnasal EGD before bariatric surgery between November 2015 and September 2016 were included in the study. In every patient we assessed the adequacy of the examination, patient tolerance, the need for sedation, and the ability to perform interventions.

**Results:** We have enrolled 50 patients (34 men and 16 women) with an average age of 42.3 years (range, 21–57 years) and an average body mass index (BMI) of 46 kg/m<sup>2</sup> (range, 39–70 kg/m<sup>2</sup>). All the patients were undergoing preoperative evaluation by transnasal small-caliber EGD. The most common comorbidities were hypertension (54%), diabetes mellitus (50%), and obstructive sleep apnea (68%). All 50 patients had successful cannulation of the duodenum's second portion with excellent tolerance. There were no sedation requirements for 46 (92%) of the 50 patients. Significant pathology was found in 14 (28%) of the 50 patients, including hiatal hernia (14%), gastritis (10%), esophageal intestinal metaplasia (6%), esophagitis (12%), gastric polyps (8%), gastric ulcer (4%) Biopsies were indicated for 26 patients and successful for all 26 (100%).

**Conclusions:** Transnasal small-caliber EGD represent a valid and safe alternative to conventional EGD for the preoperative evaluation of patients undergoing bariatric surgery. It requires minimal to no sedation in a population at high risk for complications in this setting. In addition, this technique is effective in identifying pathology that requires preoperative treatment and offers a complete examination with biopsy capabilities. This technique should be considered for all morbidly obese patients at high risk for airway compromise during EGD.

#### P.12.14

##### ENDOSCOPIC SUBMUCOSAL DISSECTION FOR GASTRIC SUPERFICIAL LESIONS: THE EXPERIENCE OF A SINGLE CENTER IN ITALY

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**Background and aim:** In Eastern countries Endoscopic Submucosal Dissection (ESD) has become the standard treatment of care for superficial gastric lesions (SGL) while in Europe the experience in this setting is still limited to few referral centers due to the low incidence of these lesions. We aimed to describe the efficacy and safety of ESD for SGL in a single Italian center.

**Material and methods:** This is a retrospective study including all consecutive patients with SGL who were referred to our center for ESD between November 2008 and June 2016. A standard ESD (SE) using a Mucosectom (Pentax Medical) or a Hybrid-ESD (HE) with the additional use of a hot snare were carried out. The resection was defined en-bloc when the entire lesion was removed in one piece. Complete resection (R0) was defined with histopathologically free horizontal and vertical margins. Incomplete resection (R1) was observed when resected margins were clearly positive. All patients underwent an upper gastrointestinal (GI) endoscopy to evaluate the presence of recurrence. Data regarding complications and their management, histopathological evaluation and follow-up were prospectively recorded.

**Results:** 54 patients (male 33, 61.1%; mean age 71±8 years) with 61 SGL were included. 47 patients had one lesion whereas 7 patients had two synchronous lesions (median size: 20 mm, range 6–60 mm) that were classified according to Paris classification. SE was performed in 50 cases (81.9%) while in the remaining 11 it was carried out as HE (18.1%). En-bloc resection was achieved in 59 cases (96.7%). Mean duration of endoscopic resection was 122±73

minutes. Adverse events were reported in 6 cases (9.9%; four GI bleedings and two perforations) and were all managed conservatively. Histopathological examination revealed intestinal metaplasia in four cases (6.7%), low grade dysplasia in 15 lesions (24.5%), high-grade dysplasia/intramucosal adenocarcinoma in 38 lesions (62.2%). Cancer with submucosal invasion <500  $\mu$ m was present in 3 cases (4.9%) whereas submucosal invasion >500  $\mu$ m was observed in 1 case (1.7%). Among neoplastic lesions R0 resection was achieved in 49 lesions (89.1%) and R1 resection was observed in 6 lesions (10.9%). Among R1 resections two lesions had both positive horizontal and vertical margins and four lesions had only positive horizontal margins. After ESD five patients underwent surgery and 49 patients (56 lesions) entered endoscopic surveillance for a mean follow-up of 170 $\pm$ 98 days. At first endoscopic control in 44 scars (78.6%) there was no evidence of macroscopic and microscopic recurrence while in 12 cases (21.4%) biopsies on scar were not performed but no macroscopic evidence of relapse was present.

**Conclusions:** ESD is a feasible, safe and effective technique for treatment of SGL. Even if in Western countries the experience in this setting is limited it may be considered as first therapeutic approach in referral centers.

## P.12.15

### PRELIMINARY RESULTS OF 3 YEARS FOLLOW-UP ACCORDING TO MAPS GUIDELINES IN ATROPHIC GASTRITIS PATIENTS

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**Background and aim:** Atrophic gastritis and intestinal metaplasia are considered to be precancerous conditions as they constitute the background in which dysplasia and intestinal-type gastric adenocarcinoma may develop. European guidelines (MAPS) recommend a scheduled 3 years surveillance for those patients who have extensive, that is both, gastric antrum and body, atrophic gastritis or intestinal metaplasia. This time interval still needs validation. The aim of the study was to assess progression of gastric histological changes at 3 years follow-up in atrophic gastritis patients.

**Material and methods:** 29 pts (female 72.4%; median age 66, range 46–83 years; median BMI 26.4, range 20.3–41.9 m<sup>2</sup>/kg; 1st degree family history of gastric cancer 3.4%; 12 pts successfully eradicated) with previously diagnosed atrophic gastritis, consecutively followed-up for gastric neoplasia surveillance at 3 years time interval after diagnosis, were considered. During gastroscopy a standard bioptic mapping was performed and biopsies were analyzed by a dedicated pathologist who expressed a report according to operative link on gastritis assessment/operative link on intestinal metaplasia assessment (OLGA/OLGIM) classification. Pts with OLGA/OLGIM between 0 and 2 (metaplasia/atrophy only located at the body) and OLGA/OLGIM 3–4 (extensive metaplasia/atrophy) were considered as separate groups.

**Results:** At baseline, 23 (79.3%) pts had OLGIM 0–2 (OLGIM 0, 1, 2 in 3 (13.0%), 8 (34.8%), 12 (52.2%)), while 6 (20.7%) pts had OLGIM 3. At 3 years follow-up, pts with OLGIM 0 and 1 decreased to 1 (4.3%) and 4 (17.4%), those with OLGIM 2 increased to 14 (60.9%), and 4 (17.4%) pts progressed to OLGIM 3. In the OLGIM 3 group, 5 (83.3%) pts remained stable and 1 (16.7%) progressed to OLGIM 4. At baseline, 23 (79.3%) pts had OLGA 1–2 (OLGA 1 and 2 in 2 (8.7%) and 21 (91.3%)), while 6 pts (20.7%) had OLGA 3.

At 3 years follow-up, the 2 OLGA 1 pts remained stable, pts with

OLGA 2 decreased to 17 (73.9%) and in 3 (13.0%) pts progression to OLGA 3 and 1 (4.3%) to OLGA 4 was observed. In the OLGA 3 group, 5 (83.3%) pts remained stable and 1 (16.7%) progressed to OLGA 4. No gastric adenocarcinoma, dysplasia or carcinoids were detected in the two groups.

**Conclusions:** Endoscopic-histological surveillance at 3 years seems to be a safe time interval in atrophic gastritis pts. Progression of OLGIM scores is observed not only in the group of pts with extensive metaplasia, but also in those with corpus-restricted metaplasia.

## P.12.16

### CAN ENDOSCOPIC MARKERS PREDICT THE GASTROESOPHAGEAL VARICEAL ERADICATION AFTER ENDOSCOPIC BAND LIGATION?

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**Background and aim:** Endoscopic Band Ligation (EBL) is performed to decrease the risk of variceal bleeding. The EBL has also been used electively for the prophylaxis of recurrent variceal bleeding (BAVENO III/IV). Furthermore, at the consensus workshop of Baveno V it was concluded that either non-selective beta-blockers or band ligation are recommended also for the prevention of a first variceal bleeding.

The most utilized and documented predictive index of first variceal bleeding was the North Italian Endoscopic Club for the Study and Treatment of Esophageal Varices (NIEC index).

Unfortunately, there aren't satisfying indicators of risk for bleeding and endoscopic features that can predict the eradication of esophageal varices. The aim of this study is to find endoscopic parameters who could predict the eradication of esophageal varices by the comparison between the main endoscopic features detected during the last ligation before the eradication and the other endoscopic sessions.

**Material and methods:** We performed from August 2013 to August 2016, 170 sessions of EBL for patients affected by portal hypertension with gastroesophageal varices by using Boston Scientific Speedband, Superview, Super7. Among the 170 sessions, we distinguished the ligation that preceded the eradication (Second to last Session) from all the others for each patient who underwent EBL. All patients included were followed from the first upper gastrointestinal bleeding to the variceal eradication. We excluded all the endoscopic sessions in which the eradication has not been recorded.

The following endoscopic parameters of esophageal varices were recorded: location (longitudinal extent of varices using the proximal margin), size (F1-F2-F3 according to the Japanese classification), blue tone (the percentage of varices with bluish coloration), and red color signs. Gastric varices were graded as absent or present, while red color signs were considered as absent, mild to moderate, or diffuse presence in all varices. Bands' number used for an effective ligation in each session was also recorded.

**Results:** 68 endoscopic sessions were included. 28 were classified as second to last (Group A), and 40 as other sessions (Group B).

Table 1= Variceal size according to the Japanese Classification

Size of varices	F1	F2	F3
Group A	0	21	7
Group B	1	22	17

Table 2= Red color signs classified as absent (-), mild to moderate (+), or diffuse presence in all varices (++)

Red Color Signs	-	+	++
Group A	6	17	5
Group B	14	20	6



The variceal location in terms of proximal margin was a mean of 28.1 cm from the superior dental arch (SDA) for the Group A and 27.2 cm for the Group B. The variceal size and red color signs are represented in Tables 1 and 2. The blue tone was 96.4% and 100% respectively. The number of arranged bands was 3.67 and 3.85 on average respectively (max=7; min=1). Gastric varices were absent in the Group A, and were observed in three cases in the Group B.

**Conclusions:** In our experience there are not useful endoscopic indicators that can predict the eradication of esophageal varices and can be used as prognostic factors of variceal bleeding. Other studies that include also clinical and laboratoristic datas are needed.

#### P.12.17

##### INTERMODALITY AGREEMENT BETWEEN CONTRAST-ENHANCED ULTRASONOGRAPHY AND CONTRAST-ENHANCED COMPUTED TOMOGRAPHY FOR THE FOLLOW-UP OF LIVER METASTASES AFTER STEREOTACTIC BODY RADIATION THERAPY

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**Background and aim:** Contrast-enhanced ultrasonography (CEUS) allows the dynamic study of liver vascularization and can be used in the follow-up of patients with liver cancer who undergo stereotactic radiotherapy (SBRT). This is a prospective pilot study aiming to evaluate the degree of intermodal correlation between CEUS and contrast-enhanced Computed Tomography (CECT) for the diagnosis of stability or progression of liver disease after 60 days from SBRT. The secondary aim is to determine the degree of intra-observer correlation between CEUS at 30 and 60 days after the end of SBRT to evaluate the effectiveness of a shorter follow-up time compared to standard follow-up time.

**Material and methods:** Consecutive patients with malignant liver lesions, with indication to SBRT, underwent baseline CEUS (T0) and CECT before SBRT. All participants then performed CEUS after 30 days (T1) and 60 days (T2) from the end of the therapy, in addition to CECT at day 60. Inter-operator agreement was calculated as K coefficient Fleiss. Intermodal agreement on the two methods was calculated for each operator individually as K Coehn and for all operators along with multivariate according Janson and Olsson and expressed as the ratio iota. The values of k and iota were interpreted according to a scale ranging from the absence of concordance k=0 to excellent agreement k>0.80.

**Results:** 24 patients were enrolled, 41 CECT and 51 CEUS were performed. Three different operators evaluated the images and the intermodal correlation was severally calculated for each operator. Interobserver correlation for contrast enhanced CT scan calculated with K Fleiss was high k=0.84. Interobserver analysis of CEUS at time T1 showed a great degree of correlation k=0.84. The interobserver analysis regarding CEUS performed at T2 was good k=0.75. The intermodal correlation calculated for operator 1, operator 2 and 3 according to Cohen k was respectively k=1.00; k=0.881 and k=0.767. Multivariate analysis of the correlation calculated as iota between all operators showed an almost perfect correlation value; iota=0.841. The comparison between CEUS at time T1 and at time T2 showed a degree of good and excellent agreement respectively for all operators k=0.767; k=1.00.

**Conclusions:** This pilot study demonstrated a good correspondence between diagnostic CEUS and CECT in defining the stability or the

local disease progression in patients undergoing SBRT. Therefore, CEUS could have an important role in the surveillance of these patients, showing accuracy, reproducibility and safety.

#### P.12.18

##### A NEW ENDOSCOPIC APPROACH WITH APPLICATION OF PLATELET-RICH PLASMA (PRP) IN THE TREATMENT OF SOLITARY RECTAL ULCER

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**Background and aim:** The Italian Society of Transfusional Medicine and Immunoematology (SIMTI) actually recommend the non-transfusional use of platelet-rich plasma (PRP) for musculoskeletal system, dentistry and maxillo-facial surgery, ophthalmology, diabetic ulcer and chronic ulcers (Grade of recommendations 1B-2B). These products, being rich in platelet growth factors, are able to stimulate tissue growth and regeneration of damaged tissues, leading to relief of pain, reduction in inflammation, increase of angiogenesis and stimulation of granulation tissue.

Gastroenterological potential uses (intestinal bowel disease, CHT and RT induced mucosites, gastrointestinal anastomotic leakage, anal fissures and ulcerations) are still scarcely explored and not currently recommended. We tried to use PRF in the management of a patient with solitary rectal ulcer (SRU).

**Material and methods:** A 54-year-old male patient was referred in April 2016 to our endoscopic service for rectal bleeding, straining during defecation and a sense of incomplete evacuation.

Colonoscopy showed at 8 cm from the anal verge a single large well-demarcated, shallow, ulcerative lesion involving the two-third of circumference of the rectal lumen with a small polypoidal growth. EUS documented a thickening of the rectal wall and internal anal sphincter and loss of distinction between the planes of the mucosa and muscularis propria.

Histopathological examination excluded neoplastic diseases and showed diagnosis of SRU.

Using the Vivostat PRF<sup>®</sup> system, a 5–6 ml autologous PRF was prepared from 120 ml blood in combination with a fibrin sealant solution and applied by a specially designed endoscopic applicator.

**Results:** The first endoscopic control performed after 2 months documented a halving size of the lesion.

A further endoscopic control documented a further size reduction. No side effects occurred.

The histological findings showed a significative reduction of the linfoplasmacellular infiltration in lamina propria and a reduction in distortion of architecture.

**Conclusions:** Endoscopic and histological findings suggest significant changes in rectal ulcer mucosal healing.

More PRP treatments will need to clarify the effectiveness of this endoscopic approach in this patient.

This technique is more easy to apply, efficacy and safe than surgical treatment which represents actually the best treatment in SRU and represent an alternative treatment to the other conservative treatments.

Although randomized controlled trials are needed, RSU may represent a further potential application of PRP.

**P.12.19****PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) IN ELDERLY PATIENTS MORE THAN 80 YEARS OLD WITH DEMENTIA: OUR EXPERIENCE**

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**Background and aim:** Percutaneous endoscopic gastrostomy (PEG) is considered the method of choice for long-term enteral artificial nutrition, and is generally performed for patients with dysphagia mainly in elderly people. Ethically and legally speaking, PEG placement requires close assessment of the patient's clinical conditions and prognosis, which may disorient endoscopists accustomed to focusing on the technical aspects of the procedure. Given the growing elderly population, endoscopists play an increasingly key role, and they are questioning the difficult choice of a PEG procedure.

**Material and methods:** We analyzed, in a descriptive, retrospective study, 219 PEG procedures "pull technique" performed from January 2008 to September 2016. Seventy-four inpatients were older than 80 years (29 males and 45 females, mean age 85.6 years, range 80–97 years). Data recorded included age, co-morbidities, indication for PEG placement and its complications. Major indications for PEG placement were: non-Alzheimer non-Parkinson neurogenic dysphagia (36 pts), Parkinson's disease (18 pts), head and neck cancer (13 pts), Alzheimer's disease (5 pts), miscellaneous (2 pts). All procedures were performed according to various conscious sedation protocols, with anesthesiologist care.

**Results:** Enteral nutrition (EN) represents a medical treatment and do not care, provided for therapeutic or preventive purposes. PEG placement can be considered a medical procedure that is relatively easy to perform and may be part of the experience of any endoscopist. Dysphagia is common among the elderly patients hospitalized with dementia in an advanced stage, causing repercussions on nutritional state and drug administration. The most common comorbidities observed were pulmonary and cardiovascular disease, without significant limitation in the execution of the procedure. There were observed no PEG-related deaths, and in particular no major complications or severe adverse events, such as buried bumper syndrome, perforation, or bleeding, after the procedure. Three peri-stomal infections and two minimal subcutaneous hematoma were observed in the site of fistula. There were two cases of pneumoperitoneum not accompanied by sepsis, that does not represent real complications, and are of no clinical significance.

**Conclusions:** PEG remains an important form of support for patients who are stabilized, and who can be shown to benefit from a preliminary period of tube feeding. The decision to refer a patient to PEG may often be influenced by nonclinical factors, thus proving to be a medical, ethical, legal and economic problem. Beyond these implications, in our experience PEG placement is much demanded for artificial enteral feeding in very elderly people, due to neurogenic dysphagia, proving to be a safe procedure, although there is still a weak clinical evidence on its actual efficacy in influencing survival and quality of life, in patients with advanced degree of dementia.

**P.12.20****ENDOSCOPIC MUCOSAL RESECTION (EMR) OF PYLORIC GLAND ADENOMA (PGA): A CASE REPORT**

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**Background and aim:** Pyloric gland-type adenomas (PGAs) are rare described neoplasms of the gastric mucosa, that represents less than 3% of gastric polyps, that occurred in an older population, with a significant female predominance. Similar lesions are also found in the duodenum, gallbladder, duct of Wirsung, rectum and in the cervix of the uterus. PGAs are characterized by thickly packed pyloric gland-type tubules, lined by an epithelium composed of cuboidal to low-columnar cells with a pale or eosinophilic cytoplasm, that express MUC6, and is not uncommon to observe an association with intestinal metaplasia, autoimmune gastritis or dysplasia. Given the malignant potential of PGAs, it's mandatory an endoscopic or surgical removal.

**Material and methods:** In April 2016, we observed a 67 years-old female visited in Emergency Department, admitted to our Unit of Digestive Endoscopy, owing to a persistent epigastric pain, abdominal distension and iron-deficiency anemia. She had a history of hypothyroidism, mild arterial hypertension, and type II diabetes mellitus, and her physical examination and laboratory test results were normal. An upper GI endoscopy examination was performed, and showed an approximately 25 mm. pedunculated polyp in the distal gastric corpus. Therefore, the polyp was lifted from muscularis propria by injecting a saline solution of epinephrine submucosally, to produce a bleb beneath the lesion, then it was captured and resected with an oval Captivator™ II snare (Boston Scientific Corporation, Natick, USA), and finally it was retrieved for histological examination.

**Results:** No complications were observed, and the patient was discharged the same evening of the procedure. Histology revealed a 2.5 cm. PGA with autoimmune gastritis and no dysplastic alterations. Since the morphological appearance of the glands and the immunohistochemical MUC6 positivity were consistent with pyloric glands, the lesion was reported as PGA. In the literature, there are very few clinical data on PGAs, because, frequently, are underdiagnosed and reported as generic dysplasia. It is possible that for some reason these lesions might be diagnosed more often than reported. Six months follow-up, consisting of gastroscopy with biopsy sampling, abdominal US and CT scan, showed no evidence of recurrence, with a benign behaviour.

**Conclusions:** PGAs are rare precancerous lesions presenting a high probability of transformation into invasive gastric adenocarcinoma and having indications to endoscopic mucosal resection or surgical removal.

**P.12.21****A PILOT STUDY ANALYZING A 1L PEG BOWEL PREPARATION BEFORE COLONOSCOPY FOR SELECTED INPATIENTS**

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**Background and aim:** The BP in inpatients is frequently inadequate and the costs related to repeated colonoscopies and prolonged hospital stays are significant. Moreover, not all patients are able to completely assume the standard high volume bowel preparation, even if in the split-dose regimen. Thus, we designed a protocol consisting of taking 1L PEG 4000 based BP and an interval up to

