case report, we describe novel approach, to treat splenic abscess via endoscopic ultrasound-guided (EUS) placement of lumen-apposing metal stent (LAMS).

CASE DESCRIPTION/METHODS: This is a 44 year old male with a past medical history significant for necrotizing pancreatitis and gastric varices who presented to our center with fever and weakness. He was previously admitted 3 months prior with post ERCP necrotizing pancreatitis which was managed successfully with endoscopic therapy. The patient reported that on the day of admission, he developed a low-grade fever and lethargy. The abdomen was soft, mildly distended, with tenderness to palpation in the left and right lower quadrants. CT of the abdomen revealed a formation of a splenic abscess measuring 5 cm x 3 cm. Blood cultures were positive for ESBL and the patient was started on antibiotics. An EUS was performed that showed a splenic abscess and an abscessogastrostomy was successfully performed using a 10 x 10 mm lumen-apposing metal stent (LAMS). One week later a repeat EGD with debriement and lavage of the abscess cavity was performed and a 10 F x 5 cm double pigtail stent was exchanged for the LAMS. On month later, a CT scan showed complete splenic abscess resolution and the double pigtail was removed. Six month CT scan showed no abscess recurrence.

DISCUSSION: EUS has been described in the drainage of pelvic, mediastinal and intraabdominal abscess. In this report we describe the first use of lumen-apposing metal stent for endoscopic management of a splenic abscess. Lee at al first reported the use of EUS guided splenic abscess drainage with the use of a double pigtail stent. This approach showed to be safe and less invasive alternative to the standard of care. In cases of worsening clinical status and reported mediobasilar as high as 79% with surgical and percutaneous drainage procedures, endoscopic therapies should be considered in the management of splenic abscess.

2128 Successful Treatment of Large Cavity Esophageal Disruptions With Transluminal Washout and Endoscopic Vacuum Therapy

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INTRODUCTION: Acute, high-grade esophageal perforation and postoperative leak after esophageal anastomotic dehiscence and other types of esophageal disruptions can lead to high morbidity and mortality due to the development of mediastinitis and thoracic contamination. Endoscopic vacuum therapy (EVT) has proven to be a feasible, safe therapy for management of esophageal wall defects, but there is limited data on the efficacy of EVT for large and severe collections. We demonstrate that large and even multiple collections could be managed by EVT with serial endoscopic debriement and washout.

CASE DESCRIPTION/METHODS: We describe a retrospective single-center analysis of two patients who underwent EVT for significant esophageal disruptions. Patient 1 developed esophageal perforation from Boerhaave Syndrome with a 4 cm disruption and 10 cm cavity, and Patient 2 developed postoperative anastomotic leak after Jevou-Lewis Esophagostomy with two separate disruptions: a 2 cm proximal disruption with a 4 cm mediastinal cavity and 14 cm gastric pull up disruption with a cavity encompassing the entire central and lower right thorax. EVT was accomplished with the use of a standard upper video endoscope, nasogastric (NG) tube and vacuum-assisted dressing kit, with endoscopic placement of a polyurethane sponge and nasogastric tube assembly into the mediastinal/ thoracic cavity. Serial washout and debriement were performed prior to each sponge insertion. Data were collected on indication, size of the cavities, time to intervention, number of procedures, time to resolution, outcomes, and adverse events.

DISCUSSION: Two patients underwent therapy with a mean age of 69.5 years. The mean size of the collections via longest cross sectional diameter was 10.7 cm. The average number of EVT procedures performed was six and average duration of therapy was 49 days. Complete resolution was achieved in both patients with EVT, endoscopic washout and debriement followed by EVT can be effective for large, even multiple, thoracic and/or mediastinal contamination following esophageal perforation and gastroesophageal anastomotic dehiscence and leaks in appropriately-selected patients. Our technique involving EVT coupled with serial washout and debriement has the potential to change the current framework to the management of severe mediastinal or thoracic contamination from anastomotic dehiscence and other types of esophageal disruptions.

2129 Lumen-Apposing Metal Stent for Benign Gastric Outlet Obstruction!

Mira Alsheikh, MD1, Khalil Kamar, MBBCh1, Fady Haddad, MD2, Sherif Andrawes, MD1.

INTRODUCTION: Endoscopic vacuum therapy (EVT) for benign gastric outlet obstruction (GOO) is safe, effective and technically feasible if performed by trained advanced endoscopists. Despite that LAMS use in malignant GOO is well defined, it is rarely performed for benign etiologies. EVT for GOO and only 4 cases have been reported in the literature. We report the case of a patient with GOO secondary to benign duodenal stricture that was successfully managed by LAMS placement.

CASE DESCRIPTION/METHODS: A 60-year-old man with history of recurrent duodenal ulcers presented for vomiting and food intolerance for five days. Two years ago he had a G00 secondary to his ulcer disease and was managed by surgical gastrojejunostomy (GJ). A subsequent marginal ulcer perforation required resection of the GJ with small bowel anastomosis and insertion of a GJ tube. Upon presentation, physical examination was notable for epigastric tenderness with no rebound or rigidity. Contrast computed tomography (CT) scan of the abdomen showed a markedly distended stomach and proximal duodenum with focal narrowing near the pancreatic head (Figure 1). Enzimatic estach reached the rectum indicating the absence of complete obstruction. Upper endoscopy showed retained solid material in stomach and an almost completely occluded “pin hole” duodenal lumen that could not be traversed with the endoscope. A wire-guided through the scope dilatation with a balloon was performed in conjunction with fluoroscopy but was unsuccessful (Figure 2) so a 10 mm x 15 mm EUS-guided LAMS was successfully deployed. Patient’s symptoms resolved and he was able to tolerate diet.

DISCUSSION: GOO usually occurs secondary to malignancy-related mass effect or luminal injury. Less commonly GOO can be attributed to benign etiologies namely ulcers, caustic ingestion and inflammation. Often managed by endoscopic balloon dilatation, benign stricture can recur. Other less favored options include self-expandable metal stents which use is limited by a high rate of migration and failure and surgical approach which provides definitive treatment but is associated with high risk of mortality and morbidity. EVT coupled with serial washout and debriement has the potential to change the current framework to the management of benign GOO. This approach is proven to be a safe alternative allowing early restoration of enteral luminal access with good short term success and satisfying safety profile. Further studies and long term follow up are recommended.

2130 Future of Endoscopy: Hybrid Argon Plasma Coagulation for Treatment of Intestinal Metaplasia of the Stomach

Elan Estifan, MD, Abdalla Mohamed, MD, Yana Cavanagh, MD, Matthew Grossman, MD.

INTRODUCTION: Hybrid Argon Plasma Coagulation (Hybrid APC) is an advancement on standard APC technology; application of APC is preceded by high pressure needless submucosal injection, with the same catheter. APC is indicated for the ablation of benign and dysplastic mucosal lesions such as vascular malformations and Barrett’s mucosa. Hybrid APC offers an advantage over efficacy and safety advantages over standard APC. The submucosal injection acts as a heat sink and disperses excess energy to ensure that the underlying layers (i.e., muscularis propria) are unaffected. Only the mucosal layer is coagulated, in its entirety.

CASE DESCRIPTION/METHODS: An 81-years old Hispanic Male was found to have a 1.2 cm mucosal nodule along the incisura of the stomach (Figure 1). He underwent endoscopic ultrasound (EUS) of the lesion, which confirmed the presence of an isolated gastric nodule with no deep invasion of the muscularis propria, consistent with a T1M0b1a endoscopic staging. He subsequently underwent endoscopic submucosal dissection (ESD) of the lesion. Pathology of the specimen revealed multifocal high-grade dysplasia, arising in the background of extensive intestinal metaplasia. The deep margin was clear; however, the lateral resection margins showed focal involvement of intestinal metaplasia with low-grade dysplasia. In light of the diffuse mucosal dysplasia, the patient was successfully treated with widespread Hybrid APC of the residual intestinal metaplasia (Figures 2 and 3). DISCUSSION: Hybrid APC is an effective and efficient treatment modality for mucosal lesions. In one series of 50 patients; 98% achieved complete macroscopic remission of Barrett’s mucosa after a median of 3.5 APC sessions and 85% achieved complete histological remission. Hybrid APC is a promising technology as thermal injury depth is targeted and reduces deep injury as well as subsequent complications when it compared with Standard APC. Applications of hybrid APC will likely continue to grow as this modality is adopted into common parlance. This case is the first to describe the use of Hybrid APC for definitive treatment of intestinal metaplasia.

2131 Endoscopic Mucosal Resection of a Proximal Esophageal Pyogenic Granuloma

Elan Estifan, MD, Varun Patel, MD, Matthew Grossman, MD.

INTRODUCTION: Asymptomatic benign esophageal granuloma are often discovered incidentally on imaging evaluation or during endoscopy. The prevalence of this disorder is unknown and it is also not clear whether the granulomas are associated with infection or a chronic inflammation. Endoscopic Mucosal Resection (EMR) for benign esophageal granuloma could be beneficial and a feasible option for treatment. EMR is a novel technique involving the use of a snare to excise a lesion in one piece by a combination of grasping, cutting, and lifting. Apparatus of the EMT assembly. The deep margin of the lesion was not included in the EMR en bloc, the proximal and distal margins were negative. The patient was asymptomatic by 3 months follow up.

DISCUSSION: Hyber APC is an effective and efficient treatment modality for mucosal lesions. In one series of 50 patients; 98% achieved complete macroscopic remission of Barrett’s mucosa after a median of 3.5 APC sessions and 85% achieved complete histological remission. Hybrid APC is a promising technology as thermal injury depth is targeted and reduces deep injury as well as subsequent complications when it compared with Standard APC. Applications of hybrid APC will likely continue to grow as this modality is adopted into common parlance. This case is the first to describe the use of Hybrid APC for definitive treatment of intestinal metaplasia.

Table 1. (A) Coronial CT of Patient 2 demonstrating a large collection of fluid and solid debris dominating the central and lower right thoracic cavity with chest tube (blue arrow) measuring 5 cm x 3 cm. Blood cultures were positive for ESBL and the patient was started on antibiotics. An EUS was performed that showed a splenic abscess and an abscessogastrostomy was successfully performed using a 10 x 10 mm lumen-apposing metal stent (LAMS). One week later a repeat EGD with debriement and lavage of the abscess cavity was performed and a 10 F x 5 cm double pigtail stent was exchanged for the LAMS. On month later, a CT scan showed complete splenic abscess resolution and the double pigtail was removed. Six month CT scan showed no abscess recurrence.

**DISCUSSION:** EUS has been described in the drainage of pelvic, mediastinal and intraabdominal abscess. In this report we describe the first use of lumen-apposing metal stent for endoscopic management of a splenic abscess. Lee et al first reported the use of EUS guided splenic abscess drainage with the use of a double pigtail stent. This approach showed to be safe and less invasive alternative to the standard of care. In cases of worsening clinical status and reported mediobasilar as high as 79% with surgical and percutaneous drainage procedures, endoscopic therapies should be considered in the management of splenic abscess.