

cannulation: 81 patients underwent conventional cannulation (*group 1*), 95 patients failed conventional cannulation and then, underwent P-duct stent insertion or precut fistulotomy (*group 2*), and 96 patients underwent primary fistulotomy (*group 3*). Complications after ERCP were defined as bleeding, post-ERCP pancreatitis, and perforation according to Cotton's criteria. **Results:** Between three groups, there were no significant differences in baseline characteristics. But bulging was more common in group 3. ERCP was successfully performed except for two cases in group 2 and one case in group 3. The post-ERCP pancreatitis rate was not significantly different between three groups (6.2%, 9.5%, 2.1%, $p < 0.094$). But hyperamylasemia was significantly different between three groups (11.1%, 17.9%, 6.3%, $p < 0.043$). There are no clinically significant bleeding or perforation in the three groups. **Conclusions:** Primary fistulotomy is effective and safe in achieving ductal access in patients with bile duct cannulation.

P-0438 Endoscopic retrograde cholangiopancreatography (ERCP)—A novel risk factor for conversion of laparoscopic cholecystectomy

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Introduction: Laparoscopic cholecystectomy is the standard care for symptomatic gallstone disease. Although open cholecystectomy has a longer convalescence, it is considered a safe approach when difficulties are encountered during laparoscopic surgery. The conversion rate 10 to 25% is documented in the literature. Although studies have shown many risk factors for conversion, the effect of preoperative ERCP is scarce worldwide. **Methods:** Two hundred and two consecutive laparoscopic (LC) and laparoscopy converted to open (LCOC) cholecystectomies performed on patients attending a tertiary referral center from 2014 to 2016 were analyzed using SPSS version 20.0. **Results:** One hundred and thirty-three LC and 69 LCOC were done with a conversion rate of 34.1%. Majority were females (76%). Mean age was 46.35 years (range 16–80). Demographic data and surgical factors are comparable in both groups. Main indications for surgery were biliary colic ($n = 81$), calculous cholecystitis ($n = 38$), choledocholithiasis ($n = 31$), and gallstone pancreatitis ($n = 10$). All patients with choledocholithiasis underwent ERCP prior to cholecystectomy. Fifty-two percent and 6% had ERCP preoperatively in LCOC and LC groups, respectively (OR—13.9, 95% CI 5.8–32.9). Eighty-one percent of the patients who underwent ERCP had a conversion ($P < 0.001$). ERCP with common bile duct stenting (11%) had no significant correlation with the conversion. There is no significant association between number of ERCP and conversion (median—2, range 1–5). Mean duration after ERCP to surgery was 20.3 weeks (range 2–48 weeks) in LCOC group. No bile duct injuries were reported in both groups. **Conclusion:** ERCP is a significant risk factor for conversion according to our data. Longer mean duration after ERCP to surgery reported in our series may have contributed to higher conversion as early surgery has shown to minimize the risk of conversion in the literature. Post-ERCP patients should be informed about the higher risk of conversion, and the surgery should be performed by an experienced surgeon to minimize the risk.

P-0439 Endoscopic papillary large balloon dilation for large or multiple common bile duct stones: Efficacy, safety, and stone recurrence

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Background: Endoscopic papillary large balloon dilation (EPLBD) has been proposed as an alternative modality for endoscopic extraction of large or multiple common bile duct stones (CBDS). Although EPLBD was found to have a high success rate and an acceptable complication rate, there have been no reports on the recurrence of CBDS after EPLBD. This study evaluated the efficacy, safety, and stone recurrence rate in patients who underwent EPLBD for CBDS. **Methods:** Seventy-eight patients who underwent EPLBD at Kobe City Medical Center General Hospital from February 2013 to March 2017 were analyzed retrospectively. Parameters were compared in patients with and without stone recurrence, and the efficacy and safety of EPLBD and the stone recurrence rate were investigated. **Results:** The mean number of stones per patient was 4.3. The overall complete stone removal rate was 93.5%. The mean number of treatments was 1.07, with 92.3% of stones removed during the first session. Mean stone diameter was 14.2 mm, and mean balloon diameter was 13.5 mm. Complications occurred in five patients (6.4%), with three experiencing bleeding and one each experiencing pancreatitis and acute cholecystitis. CBDS recurred after bile duct clearance in 16 patients (20.5%). The mean interval between stone removal and stone recurrence was 5.9 months. None of the possible risk factors associated with recurrence differed significantly in groups of patients with and without recurrence. **Conclusion:** EPLBD is safe and effective in patients with large or multiple CBDS. Risk factors for CBDS after EPLBD were identified.

P-0446 The safety of continuation antithrombotic agents undergoing percutaneous transhepatic biliary drainage

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Background: The risk of percutaneous transhepatic biliary drainage (PTBD) in patients taking antithrombotic agents remains unknown. We investigated clinical course including the complication of hemorrhagic accident, retrospectively. **Methods:** We conducted a retrospective study of 101 patients who underwent PTBD between April 2016 and March 2017 at Kyorin University Hospital, Japan. Patients who continued taking antithrombotic agents were categorized as group I, and patients who discontinued for adequate duration or who did not take any antithrombotic agents were categorized as group II. We analyzed patients' backgrounds, the rate of bleeding complications in association with PTBD, success rate of procedure, and hospitalization period after treatment. Bleeding complication was defined as continuation of bleeding from the drainage tube during more than 3 days or requirement for transfusion within 3 days. **Results:** Patient number of group I/II was 16/85, respectively. There was no difference of the patient characteristics and underlying disease between the two groups. There was no difference between the types of antithrombotic agents and the types of PTBD. Number of patients who had bleeding in associated