

a total of 928 endoscopy sessions. Control of acute bleeding, variceal recurrence, rebleeding, eradication and survival were analyzed using Baveno VI assessment criteria.

Results: EVL controlled acute bleeding during the index admission in 134 of 140 patients (95.7%). Six patients required balloon tamponade for control and 4 had a salvage TIPPS. Overall 5-day failure to control bleeding was 7.1% (n=10). Index admission mortality was 14.2% (n=20). Twenty-six (21.7%) of the surviving 120 patients had 31 subsequent rebleeding episodes after discharge from hospital. OV were eradicated in 50 of 111 patients (45%) who survived >3 months (median: 2 EVL procedures, range: 1-13 over a median of 6 months, range 0.5-55) of whom 31 recurred and 3 rebled. Sixty-nine (49.3%) of the 140 patients died during follow-up (liver failure n=46, multi-organ failure n=14, hepatorenal failure n=4, pneumonia n=1, HCC n=2, MI n=2). Cumulative survival for the 140 patients was 71.4% at 1 year, 65% at 3 years, 60% at 5 years and 52.1% at 10 years.

Conclusion: Complete eradication was achieved in <50% of patients. Although varices recurred in >50% of those eradicated, few of these rebled.

O038 IMMEDIATE OUTCOMES OF ROBOTIC RESECTION FOR HILAR CHOLANGIOCARCINOMA. INITIAL EXPERIENCE EVALUATION

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Background: Outcomes of robotic resection for perihilar cholangiocarcinoma is still controversial. Aim. Estimation of outcomes after robot-assisted resection for hilar cholangiocarcinoma. Methods. Data were collected for four years (2014-2016) in a single Russian high-volume centers. All patients underwent surgery with intention to treat for hilar cholangiocarcinoma. Diagnosis was based on medical history, CT, MRI and PTBD data. The standard procedure included major liver resection with segmentectomy 1, extrahepatic bile duct resection and Roux-en-Y biliary reconstruction with D2 lymphadenectomy. In case of insufficient (<40%) volume of FLR its hypertrophy was induced by modified variant of ALPPS (PRALPPS).

Results: Twelve patients were treated. Major liver resection was performed in 11 patients. In one case of papillary tumor type I according to Bismuth-Corlette classification extrahepatic bile ducts were resected without liver resection. Final histological examination confirmed hilar cholangiocarcinoma in 9 patients with exception of 2 patients with benign strictures and gallbladder sarcoma in one patient. In two patients there was conversion to open procedure due to vascular invasion required vascular resection and reconstruction. The mean operation time was 710 (490-980) min for totally laparoscopic cases. After initial period of the first 4 procedures the mean time decreased from 858 (560-980) min to 612 (490-690) min without significant differences. Mean blood loss was 420 (50-950) mL. The rate of R0/R1 resection was 9/1 in patients with

malignancy. The mean number of lymph nodes harvested was 8 (4-9). Severe complications (>2 according Clavien-Dindo classification) revealed in 9 patients. In six of them IIIa,b grade morbidity was observed. One patient died due to liver failure. The mean hospital stay was 22 (11-37) days.
Conclusion: The initial experience of robot-assisted resection for hilar cholangiocarcinoma suggests that robotic approach may be validated in highly selected patients. Evaluation of long-term Results is needed to clarify oncological safety.

O039 LAPAROSCOPIC INTRAOPERATIVE ULTRASONOGRAPHY REDUCES THE NEED FOR PREOPERATIVE MRCP AND ERCP IN HIGH- AND MODERATE-RISK PATIENTS WITH SUSPECTED CHOLEDOCHOLITHIASIS

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Background: Despite the existing guidelines the optimal management of suspected choledocholithiasis is still under debate. The aim of the study was the evaluation of laparoscopic ultrasound (LUS) as a rational alternative to preoperative magnetic resonance cholangio-pancreatography (MRCP) in the visualization of choledocholithiasis and in a more selective application of endoscopic retrograde cholangio-pancreatography (ERCP).

Materials and Methods: Clinical and radiological data of urgently admitted patients were collected prospectively during a five-year period. Only high- and intermediate-risk patients according to the American Society for Gastrointestinal Endoscopy guidelines were included and their data analyzed.

Results: In total, 297 patients underwent laparoscopic treatment and LUS. Preoperative MRCP was done in 87 of all. Bile duct dilatation was more evident while performing LUS compared to preoperative MRCP - 67% vs. 43.7% respectively. Bile duct size significantly correlated with choledocholithiasis using both methods; however, the Pearson correlation coefficient was higher in LUS ($r = 0.511$; $p < 0.001$) compared to MRCP ($r = 0.432$; $p < 0.001$). Choledocholithiasis was more frequently diagnosed by LUS in both groups, compared to preoperative MRCP - 35.8% and 75.5% vs. 26% and 53.1%, respectively, $p < 0.001$. The laparoscopic approach with LUS proved that in 24.5% of high-risk patients avoiding unnecessary preoperative ERCP is possible. Contrary to that, preoperative MRCP was associated with 38.3% (23) of false negative cases. The application of LUS significantly improved the visualization of small stones, 3 mm (IQR 3-1) vs. 5 mm (IQR 7-4), visualized by LUS and MRCP accordingly, $p < 0.001$. Sensitivity, specificity, positive and negative predictive values of MRCP and LUS were comparable.

Conclusion: The application of LUS in high- and moderate-risk patients with suspected choledocholithiasis is a rational approach. It substantially decreases the need for preoperative MRCP in cases of small stones, also decreasing the incidence of false indications for ERCP.