**Results:** With standard esophagogastroduodenoscope the hepatic duct was accessed through the first part of duodenum without difficulty. The endoscopy procedure was less time consuming with 100 percent success.

**Conclusion:** Due to easy access and advances in endoscopic intervention this technique helps the operating surgeon to intervene the hepatic duct under vision without the need for Interventional radiologist.

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**EPTT-029**

**MANAGEMENT OPTIONS OF DELAYED HAEMORRHAGE POST PANCREATICODUODENECTOMY**

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Delayed massive haemorrhage post pancreaticoduodenectomy is a rare but significant complication that poses a management dilemma. An experienced hepatobiliary surgeon at a tertiary centre performed an open pancreaticoduodenectomy for pancreatic head adenocarcinoma on a healthy 62yo male. Intraoperatively the patient was found to have aberrant biliary anatomy and required 2 hepatico-jejunostomy anastamoses. The patient recovered well and was discharged day 10 postoperatively.

He represented 2 weeks later with a bile leak and intra-abdominal collections requiring multiple percutaneous drainages, but was also found to have intermittent bleeding per rectum as well as through his drain tubes. Multiple computed tomography (CT) scans and angiography were performed but could not identify active contrast extravasation. Gastroscopy was also performed to exclude haemorrhage from the various anastomoses.

A decision was made for exploratory laparotomy to localize a source of bleeding but this was unsuccessful. Post operatively, the patient suffered a sentinel bleed and proceeded to interventional radiology for placement of a covered stent across the gastroduodenal artery (GDA) origin as definitive management. This decision was influenced by literature and case based reports of haemorrhage from the GDA, and was made by the treating surgeon and interventional radiologist involved in the case.

Successful management of delayed haemorrhage post pancreaticoduodenectomy requires cooperation between surgeons and radiologists, in particular interventional radiology. A step up approach should be utilized to localize a source of haemorrhage which encompasses CT and angiography, interventional radiology (coiling or a covered stent-graft), and consideration of exploratory laparotomy in selective cases.

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**EPTT-030**

**NEW MODIFICATION OF DUCT-TO-MUCOSA PANCREATICOGASTROSTOMY IS A SAFE ANASTOMOSIS FOLLOWING PANCREATICODUODENECTOMY**

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The mortality rate following Whipple’s pancreaticoduodenectomy (PD) is reported to be between 1 and 5 percent in specialist centres. Pancreaticoenteric anastomotic failure is an important contributor to mortality and a major cause of morbidity. Reconstruction after PD has become an issue of controversy during recent years. It has been suggested that pancreaticogastrostomy (PG) is associated with a lower incidence of anastomotic failure rate than pancreaticojejunostomy (PJ). Patients with soft pancreas and friable pancreatic tissue have an association with high rates of anastomotic failure. Various technical modification of the pancreatico gastric anastomosis was developed. However there is still no clear evidence with or against any type of anastomosis.

**Procedure:** Pancreas is transected and duct is cannulated with stent. The remnant of pancreas is closed with few vicryl sutures to make it firm and for hemostasis. Gastric wall is opened and mucosa is exposed. Duct to mucosa anastomosis is done by 3-5 sutures anteriorly as well as posteriorly with 5-0 prolene. Pancreatic capsule is fixed with serosa of the stomach with 2-0 silk in interrupted manner.

**Conclusion:** The new modified duct-to-mucosa single layered pancreaticogastrostomy is a safe, reliable anastomosis that can be used to restore pancreaticoenteric continuity. However, further prospective controlled trials with larger volumes are essential to support this technique.