

cases, cholangiogram in 33 and 42 patients had T-tube placement. 7 (9%) patients had intraoperative, 15 (19%) post-operative and 13 (17%) late complications.

Conclusion: MS poses a challenge for the encountering clinician. Pre-operative diagnosis is key to appropriate surgical planning, via laparoscopic or open techniques, to avoid complications.

EP03C-025

SERUM PROCALCITONIN LEVEL CORRELATES WITH SEVERITY OF ACUTE CHOLECYSTITIS

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Introduction: The objective of this study is to evaluate the role of serum procalcitonin level (SPL) in predicting the severity of inflammation and presence of bacteremia in acute cholecystitis patients.

Methods: One hundred and forty-five patients who underwent cholecystectomy for acute cholecystitis or gallbladder stones were included in this study. Blood samples were obtained in the emergency room before operation to determine complete blood count and SPL. Severity of cholecystitis was evaluated on the basis of the Tokyo Guidelines 2013 (TG13) and Parkland grading scale. Blood culture was carried out for the patients who presented fever and/or chilling.

Results: According to TG13, there were 90 patients classified as grade 1 (mild), 44 as grade 2 (moderate), and 11 as grade 3 (severe). Based on Parkland grading scale, there were 21, 34, 31, 14, and 34 patients in grade 1, 2, 3, 4, and 5 group respectively. SPL was 0.5 ± 2.3 , 6.0 ± 11.5 , and 19.4 ± 25.8 in TG grade 1, 2, and 3, and the p value was <0.001 . SPL in Parkland grade 1, 2, 3, 4, and 5 group was 0.2 ± 0.4 , 1.5 ± 6.1 , 4.8 ± 16.2 , 20.4 ± 35.6 , and 8.0 ± 15.7 respectively, and the p value was 0.008. Blood culture was carried out in 108 patients and 18 patients presented bacteremia. At the cutoff value of 0.48, SPL could predict the presence of bacteremia with sensitivity of 66.7% and specificity of 65.2%.

Conclusions: SPL was helpful in predicting the severity of acute cholecystitis and was well correlated with TG13 severity assessment criteria and Parkland grading scale.

EP03C-026

LOCAL INFILTRATION VERSUS LAPAROSCOPIC – GUIDED TRANSVERSE ABDOMINIS PLANE BLOCK IN LAPAROSCOPIC CHOLECYSTECTOMY – DOUBLE BLINDED RANDOMIZED CONTROL TRIAL

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Background: Transverse abdominal plane block (TAP) is a new technique of regional block described to reduce postoperative pain in laparoscopic cholecystectomy (LC). Recent reports describe an easy technique to deliver local anesthetic agent under laparoscopic guidance.

Methods: This randomized control trial was designed to compare the effectiveness of additional laparoscopic-guided TAP block against the standard full thickness port site infiltration. 45 patients were randomized in to each arm after excluding emergency LC, conversions, ones with coagulopathy, pregnancy and allergy to local anesthetics. All cases were four ports LC. Interventions - Both groups received standard port site infiltration with 3-5ml of 0.25% bupivacaine. The test group received additional laparoscopic guided TAP block with 20ml of 0.25% bupivacaine subcostally, between the anterior axillary and mid clavicular lines. As outcome measures the pain score, opioid requirement, episodes of nausea and vomiting and time to mobilize was measured at 6 hourly intervals.

Results: The two groups were comparable in the age, gender, body mass index, indication for cholecystectomy difficulty index and surgery duration. The pain score at six hours ($P = 0.043$) and opioid requirement at six hours ($P = 0.026$) was higher in the TAP group. These were similar in subsequent assessments. Other secondary outcomes were similar in the two groups.

Conclusion: Laparoscopic-guided transverses abdominis plane block does not give an additional pain relief or other favorable outcomes. It can worsen the pain scores.

EP03C-027

IS OUR USE OF ERCP IN THE MANAGEMENT OF PATIENTS WITH OBSTRUCTIVE JAUNDICE JUSTIFIED?

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Introduction: Healthcare caregivers are focused on quality of care and the application of evidence-based practice. In this study we aim to measure the adherence of our clinical teams to evidence-based management of patients with obstructive jaundice due to gallstones. We examined clinical outcomes, rate of unnecessarily ERCPs and related cost with root cause analysis.

Methods: A retrospective study utilizing prospectively collected data from the operative records and endoscopy department. We included all adults underwent ERCP at our tertiary care academic center from Jan 2011 to Jun 2017 with suspected choledocholithiasis. The patients were divided into three groups based on predictability of choledocholithiasis according ASGE guidelines.

Results: A total of 198 ERCPs were performed in 125 patients. The mean age was 47 ± 18.6 years. There were female majority forming 66% of the cases with a length of hospital stay of 6 ± 10.4 days. Table (1) shoe the division of patients according to the risk group defined by ASGE practice guidelines. 35 (18.8%) patients underwent a negative ERCP, 94% were patients categorized in the intermediate-risk group. 44% of repeated ERCP were due to retained stones, 39% to remove a stent, 11% due to procedure failure and 4% due to complications during the first procedure. The total potentially avoided cost was \$533,470.