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Abstract issue

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## UEG Week 2023

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fecal levels of indole-lactic-acid (ILA) compared to full-term neonates (preterm [pmol/mL] = 7, IQR 0-18, term = 10, IQR 0-252). Using our AhR-reporter system we confirmed the ability of milk IAA and I3S, and fecal ILA to activate AhR, suggesting that the levels of milk and fecal AhR-agonists are relevant for activating neonatal intestinal AhR.

Finally, to assess the role of milk AhR-ligands on epithelial barrier function, intestinal crypts were isolated from fetuses (16-20 weeks of gestation), grown into organoids and stimulated for 24h with AhR-agonists (physiological concentrations; 0.175-1 nmol/mL) and challenged with TNF $\alpha$  for 4h. The activation of Nf-kB and consequent production of IL-8 was significantly reduced by both IAA and ILA (One-way ANOVA,  $p < 0.01$  and  $p < 0.0001$ ) but not by I3S in human fetal derived organoids ( $p < 0.58$ ). In addition, the barrier function was assessed through TEER measurement. All three of the indoles restored barrier integrity damaged by TNF $\alpha$  after 72h (One-way ANOVA, IAA =  $p < 0.001$ , I3S =  $p < 0.01$ , ILA =  $p < 0.001$ ).

**Conclusion:** To conclude, our results suggest that 1) Feces of preterm neonates generate lower levels of ILA compared to full term neonates; 2) Mother milk contains AhR-ligands able to activate AhR in neonatal intestine; 3) Mother milk and neonatal feces-derived AhR-ligands reduce epithelial Nf-kB activation in fetal intestinal organoids; 4) IAA, I3S and ILA could restore intestinal barrier integrity.

All of these results suggest a possible beneficial mechanism of mother milk through intestinal AhR-activation.

**Reference:** 1. Herrmann K., et al. *Breastfeed. Med.* 2014;9:184–190. doi: 10.1089/bfm.2013.0121.

**Disclosure:** Nothing to disclose.

## OP194

### INEFFECTUAL PROCESS CONCERNING THE INITIATION OF ENTERAL TUBE FEEDING IN ACUTE PANCREATITIS. A PROSPECTIVE, INTERNATIONAL, MULTICENTER COHORT ANALYSIS OF 1088 CASES

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**Introduction:** Enteral feeding (EF) is recommended in the severe or predicted severe forms of acute pancreatitis (AP) to reduce mortality.

**Aims & Methods:** We aimed to investigate the factors leading to initiating EF in the acute phase (first three days of hospitalization) and the associations between EF and the disease outcome. 1429 prospectively collected cases from 31 centers and 12 countries were included in the analysis. EF and Non-EF patient groups were formed concerning tube feeding in the first three days of the hospital stay. We investigated the associations between pancreatic and inflammatory laboratory parameters (amylase, lipase, CRP, WBC, LDH), imaging alterations (necrosis, fluid collections, etc.), and clinical symptoms influencing the initiation of EF (abdominal pain, vomiting, etc.). We used Fisher's exact test for categorical variables and the Mann-Whitney U test for not normally distributed continuous variables. A  $p$ -value  $< 0.05$  indicates a statistically significant difference.

**Results:** EF was applied during hospitalization in 30%, 41%, and 55% of mild, moderately severe, and severe cases, respectively. Significantly higher WBC ( $p = 0.042$ ,  $p = 0.019$ ,  $p = 0.002$  on D1, D2, and D3), CRP ( $p < 0.001$  on D3), and LDH ( $p = 0.004$ ,  $p = 0.036$  on D1 and D3) were detected in the

EF group before nutritional support compared to the non-EF cases. The frequency of necrosis, pseudocyst, abdominal fluid collection (all with  $p < 0.004$ ), and the intensity of abdominal pain ( $p < 0.001$ ) were also significantly higher in the EF group before nutrition initiation. The overall mortality in this cohort was 2.8%. Notably, the mortality in the non-EF severe group was 10% higher than in the EF severe group (38% vs. 28%,  $p = 0.384$ ). **Conclusion:** All parameters influencing the EF initiation here are not part of the current guidelines. In conclusion, decision-making mechanisms for initiating EF rely on personal preferences; therefore, there is still a substantial proportion of patients with severe AP without EF (45%). Since EF is cost-effective and has a very low complication rate if applied correctly, it should be introduced to all AP cases regardless of laboratory parameters and imaging findings.

**Disclosure:** Nothing to disclose.

## OP195

### REDO ENDOSCOPIC SLEEVE GASTROPLASTY (RE-ESG): THE GROWING EXPERIENCE OF A TERTIARY CENTER

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**Introduction:** Obesity is a chronic relapsing multifactorial disease. As such, a "one and done" strategy may not lead to satisfying results in the long term for both surgical and endoscopic procedures. Endoscopic Sleeve Gastroplasty (ESG) is an effective, safe and repeatable bariatric procedure. As loss of satiety with weight regain or insufficient weight loss may occur after a primary ESG, re-ESG may play a role in such patients to improve weight loss. In this case series, we evaluate the short and medium-term outcomes of the re-ESG.

**Aims & Methods:** A retrospective analysis was performed on a prospective database including patients who underwent ESG between March 2017 and September 2022; patients who received a re-ESG because of progressive loss of satiety, insufficient weight loss and weight regain  $\geq 50\%$  after primary ESG were included in the analysis. %EWL, %TBWL, and the Bariatric Analysis and Reporting Outcome System (BAROS) questionnaire were assessed during follow-up. Weight loss parameters were calculated both after re-ESG and overall.

**Results:** Of 406 patients that underwent ESG, twenty-seven required a re-ESG (6.7%). The mean time between the primary ESG and the re-ESG was 20 months (range 7-42). Re-ESG was technically feasible in all patients and no periprocedural adverse events occurred. The adherence to follow-up was 22/27 (81.5%) at 1 month, 17/26 (65.4%) at 3 months, 15/23 (60.9%) at 6 months and 13/19 (68.4%) at 12 months.

|               | 1 month          | 3 months         | 6 months         | 12 months        |
|---------------|------------------|------------------|------------------|------------------|
| Overall %TBWL | 15.2% $\pm$ 8.0  | 19.0% $\pm$ 8    | 18.2% $\pm$ 8.1  | 18.7% $\pm$ 6.2  |
| Re-ESG %TBWL  | 10.3% $\pm$ 6    | 13.2% $\pm$ 6.4  | 13.6% $\pm$ 7.7  | 14.1% $\pm$ 7.5  |
| Overall %EWL  | 47.1% $\pm$ 21.3 | 57.1% $\pm$ 21.9 | 53.8% $\pm$ 21.9 | 55.5% $\pm$ 18.5 |
| Re-ESG %EWL   | 38.0% $\pm$ 17.2 | 47.4% $\pm$ 21.7 | 46.2% $\pm$ 22.1 | 47.8% $\pm$ 24.9 |
| BAROS score   | 3.6 $\pm$ 1.5    | 4.2 $\pm$ 1.6    | 4.2 $\pm$ 2.0    | 4.1 $\pm$ 1.8    |

Values are mean  $\pm$  standard deviation.

Table 1. Weight loss and quality of life outcomes after re-ESG.

The mean BMI was  $38.4 \pm 6.5$  kg/m<sup>2</sup> and  $35.5 \pm 6.0$  kg/m<sup>2</sup> at primary ESG and re-ESG, respectively. The overall mean %TBWL was  $18.2\% \pm 8.1$  and  $18.7\% \pm 6.2$  at 6 and 12 months, respectively. The mean %TBWL after re-