grade II: endoscopic/radiologic intervention and grade III: surgical intervention). However, this scoring system cannot be used to guide decision making when anastomotic leakage is diagnosed. Factors that may influence the severity of the anastomotic leakage are (amongst others): location of the anastomosis, estimated surface of the defect, estimated circumference of the defect, extent of contamination, severity of organ failure and time from diagnosis until therapy. However, little is known about to what extent these and other factors contribute to anastomotic leakage severity. In addition, there is a paucity of data on which leakage characteristics, dictate the success of a specific treatment. The aim of this study is to investigate which factors contribute to anastomotic leakage severity and to compose an evidence based anastomotic leakage severity score. Secondly, we aim to investigate which anastomotic leakage characteristics are associated with success of different anastomotic leakage treatments and to compare the effectiveness of different initial anastomotic leakage treatments for anastomotic leakage classified according to severity and leakage characteristics.
Materials and Methods: We will perform an international multicenter retrospective cohort study. All adult patients with anastomotic leakage according to the ECCG definition after esophagectomy and gastric conduit reconstruction for esophageal cancer are suitable for inclusion. We aim to include at least 1000 patients. The primary outcome parameter is 90-day mortality. Secondary outcome parameters are in-hospital mortality, 30-day mortality, 180-day mortality, comprehensive complications index, total number of reinterventions, hospital and ICU length of stay and hospital related costs.
Results: Data collection will take place from April 2019 until December 2019. Study results are expected in June 2020.
Conclusions: We hypothesize that we will be able to identify factors that influence the severity of the anastomotic leakage and to compose a leakage severity score. Furthermore, we expect to identify leakage characteristics which guide to the success of a specific treatment.

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MORBIDITY AND MORTALITY OF LAPAROSCOPIC D2+CME VERSUS CONVENTIONAL D2 PROCEDURE FOR LOCALLY ADVANCED GASTRIC ADENOCARCINOMA (NCT01978444)

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Background: Aiming to evaluate safety and feasibility of D2+CME procedure versus conventional D2 lymphadenectomy for locally advanced gastric cancer (AGC).
Materials and Methods: A single-center, paralleled group, randomized controlled trial was performed. The eligibly criteria were 18 to 75 years old; pathologically proven locally AGC with cT2-4, N0-3, M0; expected curative resection via laparoscope-assisted distal gastrectomy (LADG); no combination with another tumor; no history of chemotherapy or radiotherapy; no history of upper abdominal operations; perioperative ASA class I, II or III. The primary end-point was 3-year disease-free survival. The short-term outcomes were compared to evaluate the safety and feasibility of this trial.
Results: Between September 2014 and June 2018, 338 patients were randomly assigned to either the D2+CME or D2 group (D2+CME, 169; D2, 169). The D2+CME procedure exhibited advantages in intra-laparoscopic bleeding (median 15.0 [interquartile range 23.0] vs. median 37.0 [interquartile range 33.5] ml, p<0.001) and lymph node harvesting (median 34 [interquartile range 16] vs. median 27 [interquartile range 13], p<0.001). The morbidity rates of the D2 group and the D2+CME group were 16.0% (27/169) and 20.1% (34/169), respectively (p=0.322). Severe complications occurred in 2 cases in the D2 group. The mortality rate was 0% in both groups. In postoperative recovery course, flatus appeared earlier in the D2+CME group (p=0.009).
Conclusions: D2+CME procedure showed advantages in intraoperative bleeding, lymph node harvesting and postoperative recovery course. Meanwhile, no significant difference was observed in the complications between the two groups. Therefore, LADG with D2+CME appeared safe and feasible for AGC patients.

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PROSPECTIVE SCREENING INCREASES THE DETECTION OF POTENTIALLY CURABLE HEPATOCELLULAR CARCINOMA: RESULTS IN 8900 HIGH-RISK PATIENTS

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Background: Historically, only 10% of patients with hepatocellular carcinoma (HCC) are diagnosed with early-stage, potentially curable disease. In this study, chronic hepatitis virus-infected patients were prospectively screened to determine: (i) the proportion of patients diagnosed with potentially curable HCC, and (ii) survival following curative therapy
Materials and Methods: The study included 8900 chronic hepatitis virus-infected patients enrolled in a prospective screening programme, of whom 1335 (15.0%) were infected with hepatitis B virus (HBV), 7120 (80.0%) with hepatitis C virus (HCV), and 445 (5.0%) with both HBV and HCV. Screening was conducted every 6 months and included serum alpha-fetoprotein (AFP) measurement and ultrasonography. Curative treatments included liver transplantation, resection, radiofrequency ablation and/or ethanol injection.
Results: Hepatocellular carcinoma was diagnosed in 765 (8.6%) patients. Of 1602 patients with cirrhosis, 758 (47.3%) developed HCC. Curative treatment was possible in 523 (68.4%) of the 765 HCC patients. Two- and 5-year rates of overall survival in the curative treatment group were 65% and 28%, respectively, compared with 10% and 0% in the advanced disease group ($P < 0.001$).
Conclusions: Prospective screening of patients at high risk for the development of HCC increases the proportion of patients diagnosed with potentially curable disease. This may result in an increase in the number of longterm survivors. Screening strategies should focus on patients with chronic HBV or HCV infection who have progressed to cirrhosis because more than 40% of these patients will develop HCC.

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ACCURACY OF TREATMENT DECISION-MAKING IN PANCREATIC CYSTIC NEOPLASMS BASED ON AVAILABLE GUIDELINES

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Background: Cystic neoplasms of the pancreas (PCN) poses a diagnostic dilemma. Many cysts do not need surgery. However, it is important to perform resection on patients with (pre)malignant cysts. The objective of this study was to evaluate the indications for surgery and to determine the accuracy of treatment decision-making based on current guidelines, at our HPB center, a referral center for 1 million inhabitants in the eastern part of the Netherlands.
Materials and Methods: All consecutive patients with a clinical, radiological or pathological diagnosis of PCN, who were discussed in our multidisciplinary consultation between January 1, 2013 and January 1, 2019 were reviewed. Baseline patient characteristics, standardized preoperative examinations and all available preoperative imaging results were analyzed. For our accuracy analysis we compared the European guidelines (2013), the American Gastroenterological Association guidelines (2015), the revised Fukuoka guidelines (2017) and the revised European guidelines (2018).
Results: A total of 156 patients were included. Overall accuracy rate of treatment decision-making of patients who underwent surgery (n=119) was 48,1% with a positive predictive value of 47,1% and a negative predictive value of 51,4% (sensitivity 75,7%, specificity 23,2%). Table 1 shows our analysis of the available guidelines.