Learning Objectives and Outcomes

This activity is designed for physicians. Upon completion of this course, participants will be able to:

1. Exchange knowledge pertaining to current research practice and training in all aspects of surgery.
2. Design research studies to investigate new methods of preventing, diagnosing, and managing surgical diseases.

Disclosure Information

In compliance with the ACCME Accreditation Criteria, the American College of Surgeons, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. All reported conflicts are managed by a designated official to ensure a bias-free presentation. Please see the insert to this program for the complete disclosure list.
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SCIENTIFIC PROGRAM

Monday, December 3
8:30am  Morning Session
       Business Meeting
       1. President
       2. Secretary
       3. Chairman, Committee
          on Arrangements
       Presidential Address
       Presentation of Papers 1 – 5

2:00pm  Afternoon Session
       Presentation of Papers 6 – 13

Tuesday, December 4
8:30am  Morning Session
       Presentation of Papers 14 – 21

2:00pm  Afternoon Session
       Presentation of Papers 22 – 29

Wednesday, December 5
8:30am  Morning Session
       Presentation of Papers 30 – 35

11:30am  Business Meeting
       1. President
       2. Audit Committee
       3. Shipley Award for 2016

Noon  Meeting Adjournment
SOCIAL EVENTS

Sunday, December 2

9-5pm   Spa Program
        Location:  The Breakers Spa

12:30-4:00pm   Deep Sea Fishing (weather permitting)
        Hosted by:  The Breakers
        Location:  Hotel Lobby
        15 Minute Commute (Transportation Required)
        Note: A full boat is required; a second boat may Be added for an additional group of 6 guests

1-3pm    Men’s Tennis Tournament (weather permitting)
        Hosted by:  Dr. Charles Yeo
        Location:  Breakers Tennis Courts

1-3pm    Women’s Tennis Tournament (weather permitting)
        Hosted by:  Mrs. Celine Croce
        Location:  Breakers Tennis Courts

1-5pm    Men’s and Women’s Handicap Golf Tournament (weather permitting)
        Hosted by:  Dr. Martin Croce, Mrs. Gayle Meredith
        Location:  Rees Jones Course, Breakers West

2-3pm    Guided Reef Snorkeling Tour
        Location:  The Breakers Beach

2-4pm    International Ball Tournament
        Croquet/Bocce Ball
        Hosted by:  Dr. Kenneth Sharp & Mrs. Jane Sharp
        Location:  Ocean Lawn
Monday, December 3

9-5pm  Spa Program  
       Location: *The Breakers Spa*

10am- Spouses’ Coffee/Tea  
12pm  Hosted by: Mrs. Bonnie Hanks  
       Location: *Gulfstream 1,2*

10am- Island Bicycle Tour  
12pm  Location: *Hotel Lobby*

1:30- Bridge Club  
3:30pm  Hosted by: Mrs. Gayle Meredith  
       Location: *Gulfstream 4*

5:30- New Members Reception  
7pm  Location: *Mediterranean Ballroom*  
(Members and guests are invited)
Tuesday, December 4

9am- Spa Program
5pm Location: The Breakers Spa

10am- The Southern Surgical Book Discussion:
12pm Carolynn’s Club: Little Fires Everywhere
A Novel, by Celeste Ng
Discussion Leader: Mrs. Jean Tepas
Location: Gulfstream 1,2

2-4pm Eco Adventure
Hosted by: The Breakers
1:45pm Hotel Lobby
20 Minute Commute (Transportation Required)

6:30- Presidential Reception
7:30pm Location: Mediterraneanean Courtyard

7:30- Association Dinner and Dance
11pm Location: Venetian Ballroom
Wednesday, December 5

12:30- President’s Buffet Luncheon
1:30pm Location: The Circle
(Members and guests are invited)
1. HOW DURABLE IS TOTAL PANCREATECTOMY AND INTRA PORTAL ISLET AUTO TRANSPLANTATION (TP/IAT) FOR TREATMENT OF CHRONIC PANCREATITIS?

Srinath Chinnakotia*  Varvara Kirchner*
Melena Bellin*  Martin Freeman*
Steven Mongin*  David Sutherland*
Gregory Beilman*  Timothy Pruett

Background: Total-pancreatectomy and intra-portal islet cell auto-transplantation (TP/IAT) is increasingly being utilized for the management of chronic pancreatitis (CP), the benefits being removal of the root cause of pain and amelioration of diabetes via islet auto transplantation. However, the long-term durability of this operation remains unclear.

Methods: Of the 702 patients that received TP-IAT at our center, 168 patients with 10 years or greater follow up from the recent era (1996-2006) were identified for inclusion in this single-center observational study. End points included abdominal pain relief, narcotic requirements, islet graft function (Insulin-independence; Partial-graft-function=C-peptide positive, >0.6ng/dl and No function=C-peptide<0.6mg/dL), and quality of life.

Results: There were 116 patients with complete clinical data at the 5yr and 10 years. The 10-year actuarial survival was 78%. BMI>30 (p=0.04) and h/o pancreatitis >5yrs (p=0.03) predicted 10-year mortality. The pancreatitis pain relief at 5 years and 10 years was 79 % and 88% respectively. Narcotic use declined with time (p=0.001), was 43% at 5 years and 30% at 10 years. At 10 years, insulin independence and partial graft function was seen in 24% and 32% respectively (Figure 1). Pediatric patients are more likely to have islet function compared to adults (p=0.013). QoL continued to improve with time.

Conclusions: This represents the first largest series examining long-term outcomes (10 years or more) after TP/IAT. TP/IAT produces durable pain relief. Islet auto graft function is sustained even past 10 years.
Figure 1: Islet graft function at >10 years
2. IMPACT OF AFFORDABLE CARE ACT ON COLORECTAL CANCER SCREENING, DIAGNOSIS, AND SURVIVAL IN KENTUCKY

Heather F. Sinner*  
Samuel C. Walling*  
Tong Gan*  
Quan Chen*  
Bin Huang*  
B. Mark Evers  
Tom C. Tucker*  
Jitesh A. Patel*  
Avinash S. Bhakta*

Background: Kentucky (KY) is one of the most impoverished states and has the highest incidence of colorectal cancer (CRC) in the US; these disparities are greater in the Appalachian KY population (AP). This study assessed the impact of Medicaid expansion on CRC screening, diagnosis, and survival in KY.

Methods: The KY Cabinet for Health and Family Services hospital discharge files and the KY Cancer Registry were queried for individuals (≥20 years) undergoing CRC screening (defined as any method approved by the US Preventive-Services Task-Force) or diagnosed with primary invasive CRC from 2011-2016. Pre-Medicaid expansion (2011-2013; pre-ACA) was compared to post-Medicaid expansion (2014-2016; post-ACA).

Results: CRC screening was performed in 930,176 individuals and 11,441 new CRCs were diagnosed from 2011-2016. CRC screening increased substantially for Medicaid post-ACA (330%, p<0.001) compared to other insurance types, with a higher increase in CRC screening among the AP (144%) compared with non-AP (122%, p<0.01). The distribution of CRC diagnoses post-ACA increased among Medicaid (+6.7%, p<0.001), and decreased among uninsured (-4.3%, p<0.001). Among Medicaid, the proportion of early stage diagnoses (stage I/II) increased by 9.3% for AP (p=0.09), while there was little change for non-AP (-1.5%, p=0.60); increased survival was noted post-ACA (p<0.01), particularly for the AP (Figure). Controlling for covariates, survival among Medicaid CRC patients increased significantly post-ACA (HR=0.73, p<0.01).

Conclusions: Implementation of Medicaid expansion led to a significant increase in CRC screening, CRC diagnoses among Medicaid patients, and overall survival in CRC patients with Medicaid, with an even more profound impact in the AP.

Markey Cancer Center, University of Kentucky, Lexington, KY, mark.evers@uky.edu
Survival among Appalachian CRC Patients with Medicaid Pre- and Post-ACA Implementation
3. INFLUENCE OF GENDER ON SURGICAL RESIDENCY APPLICANTS’ RECOMMENDATION LETTERS

Florence E. Turrentine* John B. Hanks
Caitlin N. Dreisbach* Anneke T. Schroen*
Amanda St Ivany*

Introduction: Implicit bias has been documented at the faculty level in candidate selection within academic medicine. Gender bias is exposed when writers systematically use different language to describe attributes of male and female applicants. This study examines the presence of gender bias in recommendation letters for residency candidates.

Methods: Recommendation letters for 2016-2017 surgery resident applicants selected for interview at an academic institution were analyzed using qualitative text analysis, quantitative text mining and topic modeling. Dedoose, QDA Miner, and R analytic software were used for data management and analysis.

Results: 333 recommendation letters for 89 applicants (53% female) were analyzed. Letter writers were predominantly male (88%). Professors accounted for 57% of men, 29% of women letter writers. Letters for male applicants had higher mean word count (M=414, SD 147; F=384, SD=136, p=0.05). Standout adjectives (e.g. “exceptional”) and reference to awards, achievement, and leadership, were most often applied to male applicants. Comments on positive but general terms (e.g. “delightful”), grindstone words (e.g. “determined”), teamwork, future promise, research and work ethic were most often applied to female applicants (Table). Topic modeling and term frequencies revealed potential themes with words like “performance”, “career”, “leadership”, and “knowledge” distinguishing male applicants’ letters, while words like “care”, “time”, “patients”, and “support” distinguishing female applicants’ letters.

Conclusions: Gendered differences, examined through language and text, exist in recommendation letters for surgical residents. Implementing tools to help faculty write recommendation letters with meaningful content and edit letters for reflections of stereotypes may improve resident selection processes by reducing bias.
Table- Categories coded in surgery resident applicants’ letters of recommendation by gender

<table>
<thead>
<tr>
<th>Variable</th>
<th>Female % (count)</th>
<th>Male % (count)</th>
<th>Total Count</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement</td>
<td>36% (61)</td>
<td>64% (107)</td>
<td>168</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Awards</td>
<td>40% (89)</td>
<td>60% (132)</td>
<td>221</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Leadership</td>
<td>37% (63)</td>
<td>63% (106)</td>
<td>169</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Standout adjectives</td>
<td>45% (260)</td>
<td>55% (322)</td>
<td>582</td>
<td>0.0006</td>
</tr>
<tr>
<td>Communal/Teamwork</td>
<td>55% (212)</td>
<td>45% (174)</td>
<td>386</td>
<td>0.0057</td>
</tr>
<tr>
<td>Future Promise</td>
<td>54% (203)</td>
<td>46% (166)</td>
<td>369</td>
<td>0.0299</td>
</tr>
<tr>
<td>Grindstone</td>
<td>56% (231)</td>
<td>44% (183)</td>
<td>414</td>
<td>0.0006</td>
</tr>
<tr>
<td>Positive, but general</td>
<td>58% (136)</td>
<td>42% (98)</td>
<td>234</td>
<td>0.0006</td>
</tr>
<tr>
<td>Research</td>
<td>55% (141)</td>
<td>45% (116)</td>
<td>257</td>
<td>0.0242</td>
</tr>
<tr>
<td>Work ethic</td>
<td>59% (97)</td>
<td>41% (67)</td>
<td>164</td>
<td>0.0013</td>
</tr>
</tbody>
</table>
4. “SHOW ME THE DATA”: A RECIPE FOR QUALITY IMPROVEMENT SUCCESS IN AN ACADEMIC SURGICAL DEPARTMENT

Grace Rozycki  Larry Stevens*
Thomas Birdas*  Gary Dunnington*
Vanessa Liali*  Max Schmidt*

Introduction: Surgeons in academic medical centers (AMC) have traditionally taken a siloed approach to reducing postoperative complications. We initiated a project focusing on transparency and interprofessional collaboration in order to engage surgeons in quality improvement. Its key features were the compilation of a comprehensive Department Quality Dashboard, including metrics across the entire continuum of care, and creation of a Clinical Operations Council overseeing quality, including a Department Chief Quality Officer and Chiefs of Surgery for each for each hospital served by the department.

Methods: We compared inpatient outcomes before and after our intervention, allowing 1 quarter as the diffusion period. The outcomes analyzed were: risk-adjusted length of stay (LOS), mortality and direct cost and unadjusted incidence of complications and 30-day all-cause readmissions, as determined by the Vizient Clinical Database. We compared the outcomes of three groups: (Surgery), all other surgical departments (Other Surgery) and the remainder of the AMC (Non-Surgery). Two-tailed Students’s T-test was used for analysis.

Results: The Surgery group demonstrated sizable and statistically significant improvements in mortality (p=0.01), LOS (p=0.002), cost (p=0.0001) and complications (p=0.02) while the all-cause 30-day admission rate was unchanged (Table), resulting in mean decrease of 0.55 LOS days and direct cost savings of $2300 per surgical admission. The comparison groups had only modest decreases in some of the analyzed outcomes and an increase in complication rates.

Conclusion: Our collaborative, data-driven approach to improving Quality and Patient Safety, specifically tailored to an academic department of Surgery at a major AMC, led to prompt and significant improvements in outcomes.
Table: Comparative outcomes

<table>
<thead>
<tr>
<th>Mean values</th>
<th>Before (Q1/16 – Q4/16)</th>
<th>After (Q2/17 – Q2/18)</th>
<th>% change</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery</strong></td>
<td>N=8988</td>
<td>N=9602</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOS index</td>
<td>1.11</td>
<td>1.04</td>
<td>-6.6%</td>
<td>0.002</td>
</tr>
<tr>
<td>Mortality index</td>
<td>1.17</td>
<td>0.94</td>
<td>-19.4%</td>
<td>0.01</td>
</tr>
<tr>
<td>Direct Cost index</td>
<td>0.99</td>
<td>0.87</td>
<td>-11.8%</td>
<td>0.0001</td>
</tr>
<tr>
<td>Complication rates</td>
<td>7.9%</td>
<td>7.1%</td>
<td>-9.4%</td>
<td>0.02</td>
</tr>
<tr>
<td>Readmission rates</td>
<td>13.2%</td>
<td>13.2%</td>
<td>0%</td>
<td>0.99</td>
</tr>
<tr>
<td><strong>Other Surgery</strong></td>
<td>N=9590</td>
<td>N=10450</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOS index</td>
<td>1.06</td>
<td>1.00</td>
<td>-5.3%</td>
<td>0.01</td>
</tr>
<tr>
<td>Mortality index</td>
<td>1.09</td>
<td>1.00</td>
<td>-8.2%</td>
<td>0.55</td>
</tr>
<tr>
<td>Direct Cost index</td>
<td>0.95</td>
<td>0.96</td>
<td>+0.1%</td>
<td>0.95</td>
</tr>
<tr>
<td>Complication rates</td>
<td>5.3%</td>
<td>6.4%</td>
<td>+19.4%</td>
<td>0.12</td>
</tr>
<tr>
<td></td>
<td>7.5%</td>
<td>8.8%</td>
<td>+17.5%</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------</td>
<td>-------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Non-Surgery</strong></td>
<td>N=20998</td>
<td>N=24952</td>
<td></td>
<td>0.04</td>
</tr>
<tr>
<td>LOS index</td>
<td>1.04</td>
<td>1.01</td>
<td>-2.9%</td>
<td>0.08</td>
</tr>
<tr>
<td>Mortality index</td>
<td>1.07</td>
<td>1.02</td>
<td>-4.2%</td>
<td>0.38</td>
</tr>
<tr>
<td>Direct Cost index</td>
<td>0.96</td>
<td>0.92</td>
<td>-4.8%</td>
<td>0.008</td>
</tr>
<tr>
<td>Complication rates</td>
<td>3.5%</td>
<td>3.8%</td>
<td>+6.5%</td>
<td>0.2</td>
</tr>
<tr>
<td>Readmission rates</td>
<td>13.7%</td>
<td>13.8%</td>
<td>+0.8%</td>
<td>0.79</td>
</tr>
</tbody>
</table>

LOS: Length of stay
5. RESULTS OF A PROSPECTIVE RANDOMIZED MULTICENTER CONTROLLED TRIAL (PRMCT) EVALUATING THE IMPACT OF TECHNIQUE AND MESH TYPE IN COMPLICATED VENTRAL HERNIA REPAIR (CVHR)

Grant V. Bochicchio
Alvaro Garcia*
Jarrod Kaufman*
Chris Horn*

Kelly Bochicchio*
Bryan Sato*
Reese Stacey*
Obeid Ilahi*

Background: To our knowledge, there is an absence of PRMCTs evaluating both the impact of technique and mesh type on outcome in CVHR.

Methods: A PRMCT of 120 patients at 3 sites was conducted in which patients were randomized to either overlay vs. underlay mesh placement and mesh type (human acellular HADM vs porcine acellular PADM dermis). Key inclusion criteria included hernia size (>200 cm²), BMI <40 kg/m², HBA1C <7%, tobacco free >6 weeks and primary fascial closure. Primary outcome was recurrence at one year determined by independent examiner/imaging. Secondary outcomes included complications and patient satisfaction (SF-36). Standardized investigator training included a porcine model followed by proctoring during first case by the lead investigator.

Results: There were no significant differences in demographics between the 4 groups (age 60 ±12 years, BMI 32 ± 5, 51% female). The overall one year recurrence rate was 10.8%. There was no significant difference in recurrence rate by either mesh placement (overlay = 9.8%, underlay = 11.9%) or mesh type (HADM = 10.3%, PADM = 11.3%). Overlay patients had a significantly lower surgical site infection rate (1.6% vs. 11.9% p=0.03) and reported better physical functioning (p=0.001) and role limitation scores (p=0.04) in the early postoperative period.

Conclusion: Recurrence rates were not impacted by either anatomical placement or type of mesh. To our knowledge this represents the first PRMCT that has demonstrated similar clinical outcomes using HADM vs. PADM (not inferiority contrary to previously
published literature), with several newly discovered advantages using the overlay technique.

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Table 1. Risk Factors for Recurrence

<table>
<thead>
<tr>
<th></th>
<th>Recurrence</th>
<th>No recurrence</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>13</td>
<td>107</td>
<td>N/A</td>
</tr>
<tr>
<td>Age</td>
<td>60.08 (18.13)</td>
<td>60.69 (11.43)</td>
<td>.9068</td>
</tr>
<tr>
<td>BMI</td>
<td>29.76 (5.96)</td>
<td>31.97 (5.28)</td>
<td>.1625</td>
</tr>
<tr>
<td>Sex</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6 (46.15%)</td>
<td>53 (49.53%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>7 (53.85%)</td>
<td>54 (50.47%)</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td>.0860</td>
</tr>
<tr>
<td>White</td>
<td>9 (69.23%)</td>
<td>80 (74.77%)</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>0 (0.0%)</td>
<td>12 (11.21%)</td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>2 (15.38%)</td>
<td>11 (10.28%)</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>1 (7.69%)</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1 (7.69%)</td>
<td>4 (3.74%)</td>
<td></td>
</tr>
<tr>
<td>Duration of Current Hernia</td>
<td></td>
<td></td>
<td>.1942</td>
</tr>
<tr>
<td>6 weeks to 1 year</td>
<td>3 (23.08%)</td>
<td>12 (11.21%)</td>
<td></td>
</tr>
<tr>
<td>&gt;1 year</td>
<td>9 (69.23%)</td>
<td>91 (85.05%)</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>1 (7.69%)</td>
<td>4 (3.74%)</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>4 (30.77%)</td>
<td>29 (27.1%)</td>
<td>.7508</td>
</tr>
<tr>
<td>Hypertension</td>
<td>6 (46.15%)</td>
<td>63 (58.88%)</td>
<td>.3808</td>
</tr>
<tr>
<td>COPD</td>
<td>2 (15.38%)</td>
<td>13 (12.15%)</td>
<td>.6658</td>
</tr>
<tr>
<td>Prior surgical history</td>
<td>11 (84.62%)</td>
<td>106 (99.07%)</td>
<td>.0307</td>
</tr>
</tbody>
</table>
6. SURGICAL SITE INFECTION FOLLOWING PRIMARY CLOSURE OF HIGH RISK SURGICAL WOUNDS IN EMERGENCY GENERAL SURGERY LAPAROTOMIES IS DECREASED WITH EXTERNAL NEGATIVE PRESSURE WOUND THERAPY (NPWT)

Chad Hall*  Travis Isbell*
Justin Regner*  Stanley Kurek*
Stephen Abernathy*  Randall Smith*
Claire Isbell*  Richard Frazee

Superficial surgical site infections (SSI) after closure of contaminated and dirty wounds occurs in 12-30% of patients. A prospective randomized study from our institution of open vs closed NPWT in emergency general surgery (EGS) laparotomies reduced wound infections to 8%. Based on this data, our group adopted primary closure with external NPWT for all EGS cases. We hypothesized that the adoption of this practice would result in similar superficial SSI rates.

Methods: A retrospective observational study of a prospective protocol utilizing primary wound closure with external NPWT in consecutive EGS laparotomies patients from May 2017 to May 2018 was performed. Only patients with active soft tissue infection of the abdominal wall were excluded. Patients were analyzed for demographics, surgical indication, wound class, open abdomen management, duration of antibiotic duration, wound complications, morbidity and mortality. Fisher’s exact tests assessed associations in bivariate comparisons of categorical variables. Wilcoxon-Mann-Whitney tests were used for differences of continuous variables. Statistical significance is set at p-value<0.05.

Results: Eighty-five patients (53% male) with a median age of 65 years (range: 19-98 years) underwent EGS laparotomies. Four patients with active soft tissue infection of the abdominal wall were excluded. Eighteen wounds were classified as dirty, 52 as contaminated and 11 as clean contaminated. Preoperative risk factors for SSI included smoking 39%, diabetes mellitus 23%, COPD 23%, renal insufficiency 22%, coronary disease 22%, CHF 19%, immunosuppressive drugs 6% and prior wound infection 2%. Indication for EGS was colonic pathology in forty-six, gastric in ten, small intestine in
twenty, and other in five. Median BMI was 27 (IQR 23.4-33.0). Median duration of antibiotic therapy was 4 days (IQR=1-7 days). Open abdomen management was incorporated in 26 patients due to extensive contamination (9 patients), hemodynamic compromise (8 patients), or bowel ischemia requiring a second look (9 patients). Patient follow up occurred at a median of 20 days (14-120 days) and was obtained in all patients until wound healing or death. Six patients (7%) developed superficial SSI requiring conversion to open wound management. None of these patients developed fascial dehiscence or required wound debridement in the operating room. There were no statistically significant associations between SSI and wound class (p=0.072), antibiotic duration (p=0.702), open abdomen management, or preoperative risk factors (p < 0.1). Overall morbidity was 38% and mortality was 6%.

**Conclusions:** Primary closure of midline laparotomy incisions combined with NPWT is associated with acceptably low SSI rates. Due to the low morbidity and decreased cost associated with this technique, primary closure with NPWT should replace open wound management in the emergency general surgery population.

*Baylor Scott & White, Temple, TX, rfrazee@sw.org*
7. DEVELOPMENT OF DIABETES AFTER PANCREATICODUODENECTOMY: RESULTS OF A 10-YEAR SERIES USING PROSPECTIVE ENDOCRINE EVALUATION

Daniel W. Maxwell*  
Rodolfo J. Galindo*  
Mohammad Reheel Jajja*  
John F. Sweeney  
Marvi Tariq*  
Juan M. Sarmiento  
Zayan Mahmooth*

Background: Limited literature is available regarding the development of impaired glucose tolerance and type-II diabetes mellitus (IGT/DM) after pancreaticoduodenectomy. The primary aim was to define the diabetic phenotype and correlate pre-operative glycemic laboratories to new-onset IGT/DM after pancreaticoduodenectomy.

Methods: In this prospective study, perioperative fasting and postprandial (OGTT) plasma glucose, A1c, insulin, and c-peptide were measured in consecutive patients undergoing pancreaticoduodenectomy by the senior author from 2007-2017. American Diabetes Association definitions were used for glycemic classifications. Multivariate risk factor analysis was performed.

Results: Of 774 patients, 371 diabetics were excluded. Of 403 remaining patients, n=167 and n=236 were pre-operatively classified as non-diabetics and pre-diabetics, respectively. The incidence of IGT/DM at 120-months post-pancreaticoduodenectomy was 9.0% (non-diabetics), 22.0% (pre-diabetics), and 16.6% (overall). Pre-diabetics had 2.5x the relative risk (p=0.001) of developing IGT/DM post-operatively. Multivariate analysis identified abnormally elevated fasting-glucose, OGTT-glucose and A1c as risk factors for IGT/DM. However, multivariate analysis of patients stratified by preoperative classification identified a fasting-glucose >95mg/dL in non-diabetics, and an A1c ≥5.4% in pre-diabetics as independent risk factors for IGT/DM. Patients developing IGT/DM demonstrated elevated OGTT-c-peptide and greater differences between OGTT-glucose and fasting-glucose (Δ94.0 vs Δ29.5mg/dL; p=0.001). Homeostatic model assessment (HOMA) demonstrated insulin resistance and mild beta cell dysfunction overall, but no difference in HOMA values or insulin levels between patients who did and did not develop IGT/DM. There was no association between pathology, advancing age, or BMI and IGT/DM development.
**Conclusion:** Abnormally elevated preoperative fasting-glucose, OGTT-glucose, and A1c are significant predictors of new-onset IGT/DM following pancreaticoduodenectomy.

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ENHANCING PATIENT OUTCOMES WHILE CONTAINING COSTS AFTER COMPLEX ABDOMINAL SURGERY: A RANDOMIZED CONTROLLED TRIAL OF THE WHIPPLE ACCELERATED RECOVERY PATHWAY (WARP TRIAL)

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Neal S. McCall* Theresa P. Yeo*
Jordan M. Winter* Shawnna Cannaday*
Richard A. Burkhart* Charles J. Yeo
Michael Pucci*

OBJECTIVE(S): This study was designed to determine whether a standardized recovery pathway could reduce post-pancreaticoduodenectomy (PD) hospital length of stay (LOS) to 5 days without increasing complication or readmission rates.

METHODS: PD patients (high-risk patients excluded) were enrolled in an IRB approved, prospective, randomized controlled trial (NCT02517268) comparing a 5-day recovery pathway (WARP) to our traditional 7-day pathway (Control). WARP interventions included early discharge planning, shortened ICU stay, modified postoperative dietary and drain management algorithm, rigorous physical therapy with in-hospital gym visit, standardized rectal suppository administration, and close telehealth follow-up post discharge. The trial was powered to detect an increase in POD-5 discharge from 10% to 30% (80% power, alpha=0.05, two-sided Fisher’s Exact test, target accrual: 142 patients).

RESULTS: Seventy-six patients (37 WARP, 39 Control) were randomized from June 2015 to September 2017. A planned interim analysis was conducted at 50% trial accrual resulting in mandatory early stoppage, as the predefined efficacy endpoint was met. Demographic variables between groups were similar (Table). The WARP significantly increased the number of patients discharged to home by POD-5 compared to Control (75.7% vs. 12.8%; p<0.001) without increasing readmission rates (8.1% vs. 10.3%; p=1.0). Overall complication rates were similar between groups (29.7% vs. 43.6%; p=0.24), but the WARP significantly reduced the time from surgery to adjuvant therapy initiation (51 days vs. 66 days; p=0.005) and hospital cost ($26,563 vs. $31,845; p=0.011).

CONCLUSIONS: The WARP can safely reduce hospital LOS, time to adjuvant therapy, and cost in selected PD patients without increasing readmission risk.
Table: Patient Characteristics and Results

<table>
<thead>
<tr>
<th></th>
<th>WARP (N=37)</th>
<th>Control (N=39)</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (years)</td>
<td>65.8 ± 9.6</td>
<td>65.0 ± 9.3</td>
<td>--</td>
</tr>
<tr>
<td>Mean Body-Mass Index (kg/m²)</td>
<td>26.8 ± 4.3</td>
<td>26.1 ± 4.9</td>
<td>--</td>
</tr>
<tr>
<td>Pancreatic Fistula (Any Grade)</td>
<td>4 (10.8%)</td>
<td>2 (5.2%)</td>
<td>0.43</td>
</tr>
<tr>
<td>Delayed Gastric Emptying</td>
<td>5 (13.5%)</td>
<td>13 (33.0%)</td>
<td>0.059</td>
</tr>
<tr>
<td>Nasogastric Tube Replacement</td>
<td>5 (13.5%)</td>
<td>16 (41.0%)</td>
<td>0.010</td>
</tr>
<tr>
<td>Subjects with ≥ 1 Complication</td>
<td>11 (29.7%)</td>
<td>17 (43.6%)</td>
<td>0.240</td>
</tr>
<tr>
<td>POD 5 Discharge</td>
<td>28 (75.7%)</td>
<td>5 (12.8%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Readmission</td>
<td>3 (8.1%)</td>
<td>4 (10.3%)</td>
<td>1.00</td>
</tr>
<tr>
<td>60 Day Mortality</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Access to advanced weaponry has become more commonplace, with “Saturday Night Specials” being replaced by deadlier firearms. However, data linking ballistics to injury is lacking—in part due to federal restrictions on firearm research and in part due to a disconnect between law enforcement and trauma centers. To address this data chasm, a partnership with law enforcement was developed to describe outcomes from specific firearms.

Methods: A random sample of patients with gunshot wounds over 20 years ending 2015 and admitted to an urban trauma center was identified. Circumstances of incident, firearm type and/or caliber were extracted from police reports. Data on demographics, mortality, injury severity and clinical outcomes were collected from the trauma registry, and these datasets were linked. Firearms were stratified by velocity (high > 2500 ft/sec; low ≤ 1200 ft/sec) and caliber (large = .40 and .45; small = .20 and .25) and compared over time.

Results: Police reports were obtained on 366 patients who had a gun type or caliber documented by recovered physical evidence. The majority were male (82%) with a median age of 32. 21% of patients had an Injury Severity Score ≥ 25 and 60% required immediate operative intervention. Overall mortality was 13%, with mean firearm-related homicides increasing from 112 (1996-2000) to 143 (2011-2015) (β=1.7, p=0.024). The use of large caliber firearms increased from 4% (1996-2000) to 33% (2011-2015), whereas small caliber guns decreased from 33% to 7% over the same time period (p=0.0006). Incidence of high velocity firearm usage significantly increased from 1996 to 2015 (β=0.01, p=0.0010). Recovered shell casings (indicating more fired rounds) doubled from the first decade to the second (2 vs. 4; p=0.0006). Median hospital days increased from 2.5 to 4 from the first to the last time period (p=0.0321). Median New Injury Severity Score (NISS) increased from 11.5 to 17 over the study period (p=0.0488). The figure illustrates the changing weaponry over time and the relationship between caliber, velocity and total firearm homicides in our jurisdiction.
Conclusions: Larger caliber and higher velocity firearms have significantly increased in our city over the past twenty years in conjunction with increasing gun-related homicides, injury severity, and hospital days. Robust data sharing partnerships can be built between law enforcement and trauma centers to address the dearth of data on firearm crime and resulting injury patterns. Continued gun violence research is required to better direct prevention efforts and firearm policy, and to reduce gun-related deaths.

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Dr. Warren was President of the Southern Surgical Association in 1979 and subsequently was Chair of the Council. He was born in Miami in 1924 at Jackson Memorial Hospital, the institution he would later return to serve as Professor and Chair of Surgery. He is an outstanding exemplar of the “Greatest Generation”; a baseball player, a Marine, and great academic surgeon. His duels about the nuances of portal hypertension with Ted Drapanas will always be remembered. One might also consider that Dr. Warren was a casualty, along with Tom Starzl, of the famous “Hopkins Pyramid”. He completed his training at Michigan and Barnes Hospital, then served as faculty in the deep south of Charlottesville, Miami, and Atlanta. Our department offices in Miami were located in a cottage on the edge of a parking lot, and torrential rain often precluded access to the operating room. Dr. Warren assumed many duties in Miami including Dean of the medical school for a short period of time; he enjoyed the title “Double Dean”. Portal hypertension has gone the way of the dodo bird and sclerotherapy has preserved hepatopedal flow that Dr. Warren thought was so important, but the principles of the pathophysiology and treatment of portal hypertension, the result of rigorous scientific study, so important to Dr. Warren, remain his legacy. He was also one of the anchors of the original cooperative trial on carotid endarterectomy with Friday afternoon conference calls being early to recognize the disadvantages of operation for known “red clots”.

Dr. Warren had two concerns that deeply bothered him. One was regarding the oversight of surgical residency training in the US and the other was the lack of recognition afforded deserving African American surgeons, particularly by the SSA. Regarding the former concern, he was convinced that the AMA was the wrong home for surgical residency accreditation and that their actions were contrary to a best sense of clinical and intellectual excellence. He wished for the ACS to assume this, but it failed to respond and Orthopedic Surgery already killed that, preferring the AMA to the ACS.

Dr. Warren was President of the Southern at a time that was marked by the failure to grant membership to an African American of great distinction; this was briefly mentioned in Dr. Vicker’s presidential address last year. As a good ol’ boy between the two focal points; Dr. Warren stood between those who preferred to preserve old traditions and those that embraced the new world order. Dr. Warren was an enormous admirer of Dr. Leffall. When he was not recommended for election, Dr. Walter Lawrence’s response was to resign from the Association privately, while Dr. Warren vowed to get even. During his tenure as Chair of the Council, Dr. Warren took action on this matter. Many
do not know that the SSA officers have no vote, and only the council, i.e., Past Presidents, and active member’s ballots count in any decision made. At the meeting, he withdrew from his battered briefcase a perfect nomination document for Dr. Asa Yancey, a distinguished and respected African American surgeon from Atlanta. After lengthy discussion, the majority voted that Dr. Yancey be recommended for membership.

It was then easier to attain the election of Claude Organ, who had become Rainey William’s right hand at the University of Oklahoma and the color barrier died once and for all; the Southern grew to even greater national and international prominence. In retrospect, this was an obvious and clear decision, but at the time it was a heartfelt source of real discord by people who otherwise loved one another. The hero of this story was less Dr. Warren, as much as it was Dr. Leffall’s willingness to stand for re-election a couple years later. He was unanimously accepted.

Not long after having accepted the Chair at Emory, Dr. Warren developed maxillary sinus cancer and despite the most remarkable efforts by his friend and colleague Dr. Jurkiewicz, he became the Hathaway man with an eyepatch. Eventually, that illness came to a predictable end. Dr. Leffall’s eulogy for Dr. Warren before a packed house in Atlanta was articulate, emotional, and reflective of the unique relationship between two great surgeons, but also a re-commitment that the future of surgery is more important than the dated biases of any few people.

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11. LIVER TRANSPLANT SURVIVAL INDEX FOR MELD $\geq$35 
RECIPIENTS: MODELING RISK AND ADJUSTING EXPECTATIONS 
IN THE SHARE 35 ERA

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Irene K. Kim* 
Andrew S. Klein

Tsuyoshi Todo* 
Matthew B. Bloom*

Background: The SHARE 35 policy for liver allocation prioritizes patients with 
MELD scores $\geq$35 for regional sharing of liver allografts. This study assesses donor-
recipient interactions and derives a risk index for graft survival after transplantation in 
the MELD $\geq$35 population.

Methods: The UNOS STAR database was evaluated for deceased donor liver 
transplants with recipients’ MELD $\geq$35 between January 2006 and June 2016. 
Transplants were randomized into test and validate cohorts. Four individual models of 
graft survival spanning 90-days to 5-years were evaluated with univariate and 
multivariate Cox proportional hazards analyses against donor and recipient-specific 
characteristics. Significant factors were compiled to generate the Liver Transplant 
Survival Index (LTSI-35) and survival analyses were performed. Area under receiver 
operator curve (AUROC) was evaluated and compared to previously published 
predictive scores.

Results: Five risk groups (Very Low, Low, Moderate, High, and Severe) were 
identified with one-year graft survival rates of 90.8±0.2%, 89.3±0.3%, 85.0±0.3%, 
79.8±0.3% and 70.3±0.4% (p<0.001 across groups), respectively. Greatest risk of graft 
loss was associated with donation after circulatory death (DCD) donors (1-Year 
HR=1.61 [1.26-2.05], p=0.001), recipients’ requiring ventilator support (HR=1.32 
[1.17-1.51], p<0.001), and recipient portal vein thrombosis (HR=1.21 [1.03-1.42], 
\p=0.003). AUROC for LTSI-35 was 0.64 at 1- and 3-years and was higher than any 
other previously published score.

Conclusions: The LTSI-35 identifies risk factors for graft loss in a high-MELD 
population which portend worse outcomes. LTSI-35 performs better than other scores 
in a high-MELD population and may be used to influence donor selection and inform 
expectations for allograft survival.

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Surviving

p<0.001

Time to 25% Failures
Severe= 252 Days
High= 656 Days
Moderate= 1386 Days
Low & Very Low= n/a

5 YEAR GRAFT SURVIVAL (DAYS)
12. IMPROVED POST-PANCREATODUODENECTOMY OUTCOMES WITH EPIDURAL ANALGESIA: A 5-YEAR SINGLE INSTITUTION EXPERIENCE

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R.E. Simpson*  A. Nakeeb*
M.L. Fennerty*  C.L. Colgate*
E.P. Ceppa*  C.M. Schmidt*
M.G. House*

INTRODUCTION: Optimal pain control post-pancreatoduodenectomy is a challenge. Epidural analgesia (EDA) is increasingly utilized despite inherent risks and unclear effects on outcomes.

METHODS: All pancreatoduodenectomies (PD) performed from 1/2013-12/2017 were included. Clinical parameters were obtained from retrospective review of a prospective clinical database, the ACS NSQIP prospective institutional database and medical record review. Chi-Square/Fisher’s Exact and Independent-Samples t-Tests were used for univariate analyses; multivariate regression (MVR) was performed. Further subset analyses were performed after propensity-score matching.

RESULTS: 671 consecutive PD from a single institution were included (429 EDA, 242 non-EDA). On univariate analysis, EDA patients experienced significantly less wound disruption (0.2% vs 2.1%), unplanned intubation (3.0% vs 7.9%), pulmonary embolism (0.5% vs 2.5%), mechanical-ventilation >48hrs (2.1% vs 7.9%), septic shock (2.6% vs 5.8%), and lower pain scores. On MVR accounting for baseline group differences (gender, hypertension, pre-operative transfusion, labs, approach, pancreatic duct size), EDA was associated with less superficial wound infections (OR 0.34; CI 0.14-0.83; P=0.017), unplanned intubations (OR 0.36; CI 0.14-0.88; P=0.024), mechanical ventilation >48 hrs (OR 0.22; CI 0.08-0.62; P=0.004), and septic shock (OR 0.39; CI 0.15-1.00; P=0.050). EDA improved pain scores post-PD days 1-3 (P<0.001). No differences were seen in cardiac or renal complications; pancreatic fistula (B+C) or delayed gastric emptying; 30/90-day mortality; length of stay, readmission, discharge destination, or unplanned reoperation.
CONCLUSION: Based on the largest single institution series published to date, our data support the use of EDA for optimization of pain control. More importantly, our data document that EDA significantly improved infectious and pulmonary complications.

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In the 8th edition of the AJCC melanoma staging system, the T1b category has been redefined based solely on thickness and ulceration. NCCN guidelines recommend sentinel lymph node (SLN) biopsy for all patients with ≥5% risk of a positive SLN, including all those with T1b melanomas (0.8-1.0 mm thick). NCCN guidelines also recommend SLN biopsy for patients with ulcerated melanomas regardless of thickness. We hypothesized that the new staging system would lead to excessive utilization of SLN biopsy in patients with non-ulcerated T1b melanomas with a low risk of positive SLN.

**Methods:** The National Cancer Database 2015 Melanoma Public Use File was used to select patients undergoing SLN biopsy for thin T1 cutaneous melanoma from 2010-2015. Clinicopathologic risk factors for having a positive SLN biopsy were evaluated. Univariable and multivariable logistic regression models and classification tree analysis were performed to identify groups with high and low risk of positive SLN biopsy.

**Results:** 8,497 patients met inclusion criteria, 88% of whom underwent SLN biopsy. We selected patients undergoing SLN biopsy without ulceration with thickness 0.75-1.04 mm, staged T1b in the new 8th edition AJCC by thickness criteria alone. Independent risk factors for a positive SLN were age ≤56 (OR 1.74, 95% CI 1.38-2.17), thickness 1.0 vs. 0.8-0.9 mm (1.36, 1.09-1.70), female sex (1.36, 1.09-1.69), mitotic rate (MR) ≥ 1mm/m² (2.01, 1.54-2.64), and Clark Level IV/V (1.27, 1.01-1.59). Classification tree analysis identified two groups based on age, mitotic rate, and thickness with a risk of positive SLN biopsy <5% (Figure). These two groups made up 55% of T1b, non-ulcerated melanoma patients who underwent SLN biopsy.

**Conclusions:** The new 8th edition AJCC melanoma staging system T1b category should not be used to determine use of SLN biopsy in thin melanoma, as over one half of T1b lesions without ulceration have a low risk of positive SLN. Specifically, SLN biopsy should be reserved for T1b patients ≤56 years old with MR ≥1, and for patients >56 years with MR ≥1 only in the 1.0 mm thickness category.
Risk of Positive SLNB in T1b Non-Ulcerated Melanoma
With the increased use of molecular testing of thyroid fine-needle biopsies, the frequency and extent of thyroid resection for thyroid nodules has changed. The role of frozen section analysis of the thyroid has been markedly reduced in recent years, however many surgeons still routinely utilize this intraoperatively. We sought to determine the utility of frozen section during thyroidectomy in the era of molecular testing.

**Methods:** We reviewed 236 consecutive patients who had thyroidectomy with intraoperative frozen section analysis at our institution. We reviewed the preoperative diagnosis, frozen section diagnosis, final pathology, and if operative management changed from the initial plan based on frozen section.

**Results:** The mean age of the patients was 56 ± 14 years and 83% were female. Of the 236 patients, frozen section did not change the intraoperative management in 226 (96%). Of the 10 patients whose thyroid operation was modified, frozen section mislead the surgeon in 6 cases resulting in too much or not enough surgery. Frozen section analysis correctly influenced the surgeon’s decision to modify the extent of thyroidectomy in only 4 patients (2%).

**Conclusions:** Thyroid frozen section analysis adds cost and time to thyroid surgery without notable benefit. In our cohort, less than 2% of frozen sections accurately changed intraoperative management. Thus, we recommend against its routine use.

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15. PREOPERATIVE FRAILTY CORRELATES WITH SURGICAL OUTCOMES ACROSS DIVERSE SURGICAL SUBSPECIALTIES IN A LARGE HEALTHCARE SYSTEM

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Bobby D. Robinson* Harry T. Papaconstantinou
Erin T. Bird*

Introduction: Frailty is an emerging risk factor for surgical outcomes, however its application across large populations is not well-defined. We hypothesize frailty impacts postoperative outcomes in a large healthcare system.

Methods: Frailty was prospectively measured in elective surgery patients (1/2016-6/2017) in a healthcare system (4 hospitals/901 beds). Frailty classifications—low (0), intermediate (1-2), high (3-5)—was assigned based on the modified Hopkins score. Operations were classified as inpatient versus outpatient. Outcomes measured (30 day) included major morbidity, discharge location, Emergency Department (ED) visit, readmission, length of stay, mortality and direct-cost/patient.

Results: 14,530 patients (68.1% outpatient, 31.9% inpatient) were assessed in surgical subspecialties (cardiothoracic 4%, colorectal 4%, general 29%, oral maxillofacial 2%, otolaryngology 8%, plastic surgery 13%, podiatry 6%, surgical oncology 5%, transplant 3%, urology 24%, vascular 2%). High frailty was found in 3.4% of patients (5.3% inpatient, 2.5% outpatient). Incidence of major morbidity, readmission and mortality correlated with frailty classification in all patients (Figure, p<0.05). Inpatient cohort: length of stay (low 1.6 days, intermediate 2.3 days, high 4.1 days, p<0.0001) and discharge to facility increased with frailty (p <0.05). Out-patient cohort: ED visit increased with frailty (p<0.05). Frailty was associated with increased direct-cost in the inpatient cohort (low-$7045; intermediate-$7995; high-$8599; p<0.05).

Conclusion: Frailty impacts morbidity, mortality and healthcare resource utilization in both inpatient and outpatient operations. Additionally, inpatient cost increased with frailty. The broad applicability of frailty (across surgical specialties) represents an opportunity for risk stratification and patient optimization across a large healthcare system.

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16. CHOLECYSTECTOMY DURING THE THIRD TRIMESTER OF PREGNANCY: PROCEED OR DELAY?

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Jason K. Sicklick*  

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California Cholecystectomy Group

Background: Current guidelines suggest that cholecystectomy during the third trimester of pregnancy is safe for both the mother and the baby. However, no population-based data have examined this issue. The aim of this analysis was to compare the outcomes of cholecystectomy during the third trimester with those performed in the early postpartum period in a large population.

Methods: The California Office of Statewide Health Planning and Development database was queried from 2005 to 2014. Women undergoing cholecystectomy during the third trimester of pregnancy (n=247) were compared to those having this procedure in the three months post-partum (n=12,798). Patient demographics as well as maternal delivery and cholecystectomy-related outcomes were compared by standard statistics as well as after adjustments for age, race, comorbidities, insurance status and hospital setting.

Results: Women undergoing cholecystectomy during the third trimester were older (27 vs 24 years, p<0.001) but did not differ in race or insurance status. Cholecystectomy during pregnancy was less likely to be accomplished as an outpatient (12 vs 36%, p<0.001) and more likely to be performed open (12 vs 2%, p<0.001). Maternal and cholecystectomy outcomes are reported in the Table. Preterm labor, eclampsia, antepartum hemorrhage, bile duct injuries as well as hospital stay and readmissions all were increased significantly when cholecystectomy was performed during pregnancy.

Conclusions: Maternal and procedure-related outcomes are worse when cholecystectomy is performed during the third trimester of pregnancy. Preterm labor is associated with multiple adverse infant outcomes. Whenever possible, cholecystectomy should be delayed until the postpartum period.

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<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Cholecystectomy in 3(^{rd}) trimester N=247</th>
<th>Cholecystectomy post-partum N=12,798</th>
<th>p-values*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preterm labor</td>
<td>31.2%</td>
<td>10.8%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Eclampsia(^{†})</td>
<td>9.7%</td>
<td>6.0%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>C-section</td>
<td>39.3%</td>
<td>36.4%</td>
<td>0.36</td>
</tr>
<tr>
<td>Hemorrhage(^{‡})</td>
<td>5.7%</td>
<td>2.3%</td>
<td>&lt;0.002</td>
</tr>
</tbody>
</table>

| Cholecystectomy           |                                               |                                      |           |
| Bile leak                 | 0.0%                                          | 0.8%                                 | 0.15      |
| Bile duct injury          | 0.8%                                          | 0.2%                                 | <0.02     |
| LOS (days)                | 3.0                                           | 1.0                                  | <0.001    |
| Readmissions              | 8.4%                                          | 3.9%                                 | <0.004    |

*Adjusted, \(^{†}\)And Pre-eclampsia, \(^{‡}\)Antepartum, LOS=length of stay
17. OUTLIER SURGEON RE-EXCISION RATES IN BREAST CONSERVING THERAPY: A MEASURE OF LOW-VALUE CARE

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Richard C. Gilmore*   John L. Cameron
Peiqi Wang*            Lisa K. Jacobs*
Susan Hutfless*        David M. Euhus*
Matthew J. Weiss*      Martin A. Makary

Introduction: Re-excision procedures following breast-conserving therapy (BCT) may be necessary despite using best practices in surgical technique, however a surgeon’s re-excision rate should fall within an expected range. We aimed to describe the rate of breast re-excision in patients undergoing BCT; additionally, to compare re-excision rates before and after the establishment of 2014 SSO-ASTRO guidelines recommending no ink on tumor.

Methods: A retrospective analysis of Medicare fee-for-service claims over a four-year period (January 1, 2012- June 30, 2016) was performed to identify surgeon-level re-excision rates after BCT. A re-excision was defined as a subsequent breast resection procedure within 1 year of the initial BCT. Outlier practice pattern was defined as a re-excision rate of >30%. Logistic regression was used to evaluate surgeon characteristics associated with an outlier practice pattern.

Results: We identified 4,774 U.S. surgeons who performed BCT during the study period. Median breast re-excision rate by surgeon was 18.2% (Range = 0% - 83.3%). A total of 889 (18.6%) surgeons had a re-excision rate >30%. Outlier breast re-excision rates were associated with greater than 20 years in practice (OR=1.28, 95% CI: 1.05-1.56), practice in a micropolitan (OR=1.42, 95% CI: 1.14-1.77) or rural (OR=1.89, 95% CI: 1.26-2.85) setting, and low volume of cases per year (<50 OR=2.32, 95% CI: 1.81-2.97; <20 OR=3.48, 95% CI: 2.71-4.46). Between 2012 and 2016, the percentage of surgeons with re-excision rates exceeding 30% decreased from 22.2% in 2012 to 13.9% in 2016. Prior to the establishment of the 2014 SSO-ASTRO guidelines, the median breast re-excision rate was 20% compared to 15.8% afterwards.
Conclusions: Marked variation exists in surgeon re-excision rates among patients undergoing BCT, which may represent unnecessary surgery on individual patients and a financial burden to the healthcare system. Formalizing a re-excision frequency metric could have implications for quality improvement and data-driven surgeon feedback aimed at reducing unwarranted variation.

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18. REMOTE-ACCESS THYROIDECTOMY: A MULTI-INSTITUTIONAL NORTH AMERICAN EXPERIENCE WITH THE TRANSAXILLARY, RETROAURICULAR, AND TRANSORAL ENDOSCOPIC VESTIBULAR APPROACHES

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Christopher R. Razavi* Ralph P. Tufano*  
Meghan E. Garstka* Emad Kandil  
Lena Chen*

Objectives: Post-thyroidectomy neck scarring can negatively impact patient quality of life. As such, many remote-access (RAC) approaches to the thyroid have been described, including the transaxillary (TA), retroauricular (RA), and transoral endoscopic vestibular approaches (TOETVA). These techniques have been popularized in Asia, but adoption has been slow in North America. We aim to examine multi-institutional North American outcomes with RAC thyroidectomy in the context of these institutions’ transcervical thyroidectomy (TC) outcomes.

Methods: North American cases of lobectomy and total thyroidectomy via TA, RA, and TOETVA were reviewed at 2 tertiary care hospitals. Demographics/characteristics, outcomes and complications were compared to these same measures in patients undergoing lobectomy and total thyroidectomy via TC by the two primary RAC surgeons at each institution from 2015-2018. Patients who underwent parathyroidectomy or concomitant procedures, such as central/lateral neck dissections, were excluded.

Results: 201 RAC thyroidectomies were attempted (77 TOETVA, 70 TA, 54 RA) while 382 TC thyroidectomies were performed. Demographics are found in Table I. 200/201 (99.5%) of RAC cases were completed via the intended approach with a median operative time of 150 (60-480) minutes, compared to 105 (25-567) minutes (p < 0.0001) in the TC cohort. 3/201 patients (1.5%) had permanent recurrent laryngeal nerve (RLN) injury compared to 3/382 (0.8%), p=0.42, in the RAC and TC cohorts respectively. 3/201 (1.5%) patients had hematomas compared to 1/382 (0.3%) in the RAC and TC cohorts respectively (p=0.12).
Conclusions: RAC thyroidectomy can be performed in a select North American patient population with outcomes comparable to the TC approach.

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<table>
<thead>
<tr>
<th></th>
<th>RAC</th>
<th>TC</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of Lobectomies</td>
<td>161/201 (80%)</td>
<td>245/382 (64%)</td>
<td>0.0001</td>
</tr>
<tr>
<td>BMI (mean, kg/m²)</td>
<td>27.4 +/- 5.8</td>
<td>31.7 +/- 8.3</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Nodule Size (mean, cm)</td>
<td>2.8 +/- 1.6</td>
<td>2.9 +/- 1.9</td>
<td>0.72</td>
</tr>
<tr>
<td>Age (mean, years)</td>
<td>43.9 +/- 12.1</td>
<td>53.5 +/- 14.7</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

RAC: remote-access thyroidectomy; TC: transcervical thyroidectomy
19. THE IMPACT OF NEW VASCULAR FELLOWSHIP PROGRAMS ON THE VASCULAR SURGERY OPERATIVE VOLUME OF RESIDENTS IN ASSOCIATED GENERAL SURGERY PROGRAMS

William P. Robinson*  
Alec Shannon*  
John B. Hanks  
John R. Potts, III

BACKGROUND: General surgery (GS) resident vascular surgery (VS) operations significantly declined over the last 15 years. We hypothesized that vascular surgery fellowship programs (VSFPs) may contribute to that decline. This study examined the effect of establishing new VSFPs on VS case volumes of residents in associated GS programs.

METHODS: GS programs were reviewed if associated with VSFPs accredited since 7/1/2002 that had ≥1 graduate. (n.b. GS caselogs are available only since 2002-3) The total VS cases as surgeon by residents in those programs was analyzed prior to- and after- matriculation of the first fellow into the associated VSFP.

RESULTS: 22 programs were available for analysis. Because VSFP start dates varied, GS caselog data was variably available from 0-14 years before- and 0-14 years after the first fellows in the associated VSFPs. In the 12 programs with 4 years’ data before- and after matriculation of the associated VSFPs’ first fellows, VS cases declined from 143.65 to 114.04 in the four years after (p=0.0134). In all 16 programs with 4 years’ data after matriculation of the associated VSFP’s first fellow, VS cases declined from 123.37 to 103.23 (p=0.0232).

CONCLUSIONS: New VSFPs diminished the peak VS operative volume of residents in associated GS programs, thereby contributing to the declining national average number of VS cases done by GS residents. Nevertheless, resident VS case volumes remained robust in most GS programs associated with new VSFPs. Further study is required to determine both the resident perception and overall impact of VSFPs on associated GS training.

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All programs with data 4 years PRIOR to- through 4 years AFTER matriculation of the first fellows in associated VSFPs at Year 0 (n=12)
20. **THE EFFECT OF RENAL DIAGNOSIS ON SURVIVAL IN SIMULTANEOUS LIVER KIDNEY TRANSPLANTATION**

Robert M. Cannon*  
Eric G. Davis*  
Christopher M. Jones*  
Devin E. Eckhoff

**Background:** Simultaneous liver-kidney transplantation (SLK) is lifesaving; however, the utility of allocating two organs to a single recipient remains controversial, particularly in the face of potentially inferior survival. This study aims to determine the effect of renal indication for transplant on SLK outcomes.

**Methods:** All adult recipients of combined whole liver-kidney transplant in the UNOS database from 2003-2016 with a renal diagnosis of hypertension (HTN), diabetes (DM), acute tubular necrosis (ATN), or hepatorenal syndrome (HRS) were examined. Comparisons were made between the HTN/DM group and the ATN/HRS group using standard statistical methods.

**Results:** There were 1204 patients in the HRS/ATN group versus 1272 patients in the HTN/DM group. HTN/DM patients were slightly older (58.1 vs. 56.4 years; p<0.001), more likely to have liver disease due to chronic viral hepatitis (33.2% vs. 21.5%; p<0.001), and less acutely ill (mean MELD of 27.2 vs. 33.1; p<0.001) than their HRS/ATN counterparts. The prevalence of NASH was 16.8% in both groups. Donor demographics were similar in both groups, although HTN/DM patients were more likely to have a local (81.6% vs. 67.7%; p<0.001) rather than regional donor. Patient survival at 1, 3, and 5 years was significantly lower in the HTN/DM group (87.4%, 78.2%, 71.2% vs. 90.7%, 84.1%, 76.6%, median 118 vs. 139.7 months; p<0.001). HTN/DM patients were at significantly higher risk of death (HR 1.533; p<0.001), liver graft loss (HR 1.611; p<0.001), and renal graft loss (HR 1.592; p<0.001) than ATN/HRS patients on multivariable analysis.

**Conclusions:** Despite a lower acuity of illness, HTN/DM patients have inferior survival following SLK than those with ATN/HRS. This should be accounted for in risk adjustment and allocation schemes.

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Patient Survival

Survival Probability

Survival in Months

Renal Diagnosis

ATN/HRS vs DM/HTN
21. FIRST, DO NO HARM: RETHINKING ROUTINE DIVERSION IN SPHINCTER-PRESERVING RECTAL CANCER SURGERY

Paul E. Wise
William Chapman, Jr.
Melanie Subramanian*
Senthil Jayarajan*

David R. Rosen*
Matthew Mutch*
Steven Hunt*

Background: While diverting stomas purportedly reduce anastomotic leak and reintervention rates after sphincter-preserving rectal cancer operations, the morbidity and increased healthcare utilization of these stomas have been well documented. We hypothesize that routine temporary diversion does not decrease the rate of leak or reintervention in rectal cancer patients undergoing sphincter-sparing procedures.

Methods: The Healthcare Cost and Utilization Project (HCUP) Florida State Inpatient Database (SID) was queried for patients undergoing sphincter-preserving proctectomy for cancer (2005-2015). Matched cohorts defined by diversion status were created using propensity scores based on patient and hospital characteristics. Anastomotic leak rate, invasive reintervention rate, and cumulative costs over 90 post-discharge days were analyzed with hierarchical regression.

Results: Of 9,522 identified proctectomy recipients, each cohort included 2,124 persons after matching. Leak rates did not significantly vary between cohorts (4.2% vs. 4.3%, $p=0.88$), but diversion was significantly associated with higher rates of non-elective reintervention compared to nondverted patients (13.8% vs 6.5% respectively, $p<0.01$) (Figure). In hierarchical models, diversion remained unassociated with leak (OR 0.96; 95%CI 0.69–1.32) but significantly associated with reintervention (OR 2.69; 95%CI 2.09–3.48). Additionally, median unadjusted costs were significantly higher in the diverted group ($21,380 vs $14,990, $p<0.01$). Adjusted costs among diverted patients remained 34.7% higher than in nondverted patients ($p<0.01$).

Conclusions: Diversion did not reduce leak rates but was significantly associated with increased risk of non-elective reintervention and higher 90-day costs after sphincter-sparing proctectomy. We therefore challenge the paradigm of routine diversion in rectal cancer surgery. Further study is needed to identify which patients most benefit from diversion.

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USE OF HEPATITIS C Ab POSITIVE DONOR LIVERS IN HCV SERONEGATIVE LIVER TRANSPLANT RECIPIENTS

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Flavio Paterno*  
Keith Luckett*  
Michael Schoech*  
Kurram Bari*  
Kamran Safdar*  
Tiffany E. Kaiser*  
Nadeem Anwar*  
Tayyab S. Diwan*  
Michael J. Edwards  
Madison C. Cuffy*

Given the shortage of available liver grafts and increasing waitlist mortality, transplantation of Hepatitis C antibody positive, NAT negative (HCVAb-pos) livers into HCV seronegative recipients may expand the donor pool. Having previously described the sentinel experience of HCVAb-pos allografts in seronegative patients, we now report the growth and extended followup of this program for 51 patients, representing the largest experience in the current era.

Methods: A prospective review of all HCV seronegative liver transplant (LTx) recipients transplanted with an HCVAb-pos organ between 3/2016 and 6/2018 was performed. All HCVAb-pos organ recipients underwent HCV testing at 3 months and 1 year post-LTx to determine HCV transmission.

Results: 51 HCV seronegative candidates received HCVAb-pos organs; 63% male, median age 58 years (36-69) and median MELD score of 23. One recipient was excluded due to death from primary graft non-function. HCV disease transmission occurred in 5 recipients (10%) by 3 months post-LTx. Of these, four (80%) underwent anti-HCV treatment with eradication of virus. No patient found to be negative at 3 months seroconverted at one year follow-up. Although all the donors were high risk and within the eclipse period after a re-infection, a 10% rate of HCV transmission is much higher than expected, suggesting occult HCV infection in donors as the probable mode of HCV transmission.
**Conclusion:** We report the largest experience with LTx from HCVAb-pos donors into 50 seronegative recipients with a HCV transmission rate of 10% with no late conversions at 1 year. Due to availability of safe and effective HCV DAA therapies, use of such organs should be considered to increase the donor organ pool.

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23. A MULTIDISCIPLINARY APPROACH REDUCES CLOSTRIDIUM DIFFICILE INFECTIONS IN ADULT SURGICAL PATIENTS

Megan C. Turner* Becky Smith*
Shay Behrens* Rebeckah Wrenn*
Wendy Webster* Regina Woody*
Kirk Huslage* Christopher Mantyh

Background: In 2017, our hospital was identified as a “High Outlier” for postoperative Clostridium difficile infections (CDI) in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) Semi-Annual Report (SAR). The Department of Surgery initiated an CDI Task Force with representation from Surgery, Infectious Disease, Pharmacy, and Performance Services to analyze available data, identify opportunities for improvement, and implement strategies to reduce CDI.

Methods: Strategies to reduce CDI were reviewed from the literature and multidisciplinary strategies were initiated.
1) Antimicrobial stewardship optimization of perioperative order sets to avoid cefoxitin and fluoroquinolone use was completed. Penicillin allergy assessment and skin testing was concomitantly implemented.
2) Increased use of ultraviolet (UV) disinfectant strategies for terminal cleaning of CDI patient rooms.
3) Increased hand-hygiene and PPE signage as well as monitoring in high-risk CDI areas.
4) Improve diagnostic stewardship by an electronic best practice advisory to reduce inappropriate CDI testing.
5) Education through surgical grand rounds.
6) Routine data feedback via NSQIP and NHSN CDI reports.

Results: The observed rate of CDI decreased from 1.19% in October 2016 to 0.70% in September 2017. Cefoxitin use decreased by 62%. CDI testing for patients on laxatives decreased from 23% to 7%. Terminal cleans with UV increased by 58%. Handwashing compliance increased by up 12%

Conclusions: Our multidisciplinary CDI reduction program has demonstrated significant reduction in CDI. It is effective, straightforward to implement and monitor, and can be generalized to high-outlier and at-goal hospitals to meet this important quality metric and better serve patients.

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Figure: Observed Clostridium Difficile Occurrence Rates: 2 Year Quarterly Trend by ACS NSQIP (C.diff & CD: Clostridium Difficile, ACS NSQIP: American College of Surgeons National Surgical Quality Improvement Program)
24. A POPULATION BASED ASSESSMENT OF SELECTIVE DRAIN PLACEMENT DURING PANCREATODUODENECTOMY USING THE FISTULA RISK SCORE

Jordan M. Cloyd* Mary Dillhoff*
Dimitrios Xourafas* Timothy M. Pawlik

Background: Recent studies on postoperative pancreatic fistula (POPF) prevention suggest that omission of perioperative drains is safe for low or negligible risk patients undergoing pancreatoduodenectomy (PD). However, this proposed pathway has not been validated in a nationwide cohort.

Methods: The ACS-NSQIP targeted pancreatectomy database from 2014-2016 was queried to identify patients who underwent PD. Using a previously validated modified fistula risk score (mFRS), patients were stratified as low/negligible or high/intermediate risk. Multivariate regression models were used to analyze the effect of intraoperative drain placement on relevant postoperative outcomes in both high- and low-risk patients.

Results: Among 6730 patients undergoing PD, 3375 (50%) were high-risk and 3355 (50%) were low-risk. Among high-risk patients, drain placement (n=3093, 92%) was associated with a higher rate of POPF (26% vs 16%, p=0.0003), CR-POPF (20% vs 12%, p=0.0015), and extended LOS (9 vs 7 days, p<0.0001), but less serious morbidity (27% vs 33%, p=0.0325). Similarly, drain placement in low-risk patients (n=2785, 83%) was associated with a higher rate of POPF (11% vs 6%, p=0.0006) and extended LOS (8 vs 7 days, p<0.0001), yet lower overall (25% vs 31%, p=0.0033) and serious (15% vs 20%, p=0.0076) morbidity. On multivariate logistic regression, drain placement was associated with an increased odds of CR-POPF and a reduced incidence of serious morbidity among both high- and low-risk patients (Table).

Conclusions: In this national cohort, the mFRS was unable to stratify patients relative to the need for selective drain placement during PD. For both high- and low-risk patients, perioperative drain placement was associated with increased rates of POPF, CR-POPF, and extended LOS but decreased incidence of serious morbidity.

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Table: Independent Association of Perioperative Drain Placement with Postoperative Outcomes Based on Modified Fistula Risk Score

<table>
<thead>
<tr>
<th></th>
<th>High FRS</th>
<th></th>
<th>P-value</th>
<th>Low FRS</th>
<th></th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95%CI</td>
<td></td>
<td>OR</td>
<td>95%CI</td>
<td></td>
</tr>
<tr>
<td>Any POPF</td>
<td>1.71</td>
<td>1.22-2.39</td>
<td>0.0017*</td>
<td>1.88</td>
<td>1.29- 2.73</td>
<td>0.0009*</td>
</tr>
<tr>
<td>CR-POPF</td>
<td>1.72</td>
<td>1.18-2.51</td>
<td>0.0046*</td>
<td>1.53</td>
<td>1.02- 2.29</td>
<td>0.0356*</td>
</tr>
<tr>
<td>Any Morbidity</td>
<td>0.84</td>
<td>0.65- 1.09</td>
<td>0.1999</td>
<td>0.71</td>
<td>0.58- 0.86</td>
<td>0.0009</td>
</tr>
<tr>
<td>Serious Morbidity</td>
<td>0.71</td>
<td>0.54-0.93</td>
<td>0.0126*</td>
<td>0.71</td>
<td>0.56-0.90</td>
<td>0.0051*</td>
</tr>
<tr>
<td>LOS&gt;8 days</td>
<td>1.53</td>
<td>1.18-1.97</td>
<td>0.0010*</td>
<td>1.51</td>
<td>1.24- 1.82</td>
<td>&lt;0.0001*</td>
</tr>
<tr>
<td>Mortality</td>
<td>0.61</td>
<td>0.28-1.32</td>
<td>0.2181</td>
<td>0.87</td>
<td>0.45- 1.67</td>
<td>0.6815</td>
</tr>
<tr>
<td>Readmission</td>
<td>0.82</td>
<td>0.60- 1.11</td>
<td>0.2091</td>
<td>1.01</td>
<td>0.77- 1.31</td>
<td>0.9337</td>
</tr>
<tr>
<td>Reoperation</td>
<td>0.53</td>
<td>0.34- 0.83</td>
<td>0.0060*</td>
<td>0.87</td>
<td>0.56- 1.35</td>
<td>0.5521</td>
</tr>
</tbody>
</table>

Controlling for Age, BMI, ASA class, preoperative radiation therapy, pancreatic duct size, pancreatic gland texture and preoperative total bilirubin levels (*p<0.05).
Introduction: Pancreaticoduodenectomy is historically associated with incisional surgical site infection (iSSI) rates between 15-20%. Prospective studies have been mixed with respect to the benefit of individual interventions directed at decreasing iSSI. We hypothesized that the application of a perioperative bundle during pancreaticoduodenectomy would significantly decrease the rate of iSSI.

Methods: An initial cohort of 150 consecutive post-pancreaticoduodenectomy patients were assessed within 2-4 weeks of operation to determine baseline iSSI rates. The Centers for Disease Control definition of iSSI was utilized. A four-part perioperative bundle was then instituted for the second cohort of 150 patients. This bundle consisted of a double ring wound protector, gown/glove and drape change prior to fascial closure, irrigation of the wound with bacitracin solution, and a negative pressure wound dressing over the skin closure left in place until postoperative day 7, or day of discharge. 300 patients provided 80% power to detect a 50% risk reduction in iSSI.

Results: Cohorts 1 and 2 were similar with respect to age (68 vs 69 yrs, p=0.92), gender (male, 51% vs 55%, p=0.64), BMI (26 vs 26, p=0.99), neoadjuvant therapy (32% vs 25%, p=0.37), median operative time (222 vs 215 min, p=0.36) and the presence of a preoperative stent (79% vs 62%, p=0.064). The iSSI rate was 22.3% in the initial cohort. This rate was higher than both our institutional database (13%) and NSQIP reporting (11%). Within cohort 2, the iSSI rate decreased significantly to 10.7% (n=15; p=0.01). All four components of the bundle were utilized in 91% of cohort 2 patients.

Conclusion: In this cohort study of 300 consecutive patients who underwent pancreaticoduodenectomy, the implementation of a four-part bundle decreased iSSI from 22% to 11%.

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The diagnosis of BTAI has increased, likely due to more sensitive imaging. Nearly 70% get NON-OP care. TEVAR treatment improves outcomes relative to OAR. Part of the proportional increase in TEVAR use may represent over-treatment of lower grade BTAI amenable to medical management, and warrants further investigation.
27. ROBOTIC PANCREATICODUODENECTOMY IS THE FUTURE: HERE AND NOW

Sharona B. Ross*  
Timothy J. Bourdeau*  
Janelle D. Spence*  
Joshua Alvio*  
Iswanto Sucandy*  
Alexander S. Rosemurgy, II

Introduction: The advent of robotics has greatly impacted Surgery. This study was undertaken to examine our results with robotic pancreaticoduodenectomy and to compare our results with those predicted by NSQIP and those reported through NSQIP.

Methods: Since our first robotic pancreaticoduodenectomy, we have followed patients with IRB approval. We determined predicted outcomes for our patients using the ACS NSQIP Surgical Risk Calculator and, for comparison, utilized patients undergoing pancreaticoduodenectomy 2012-17 in NSQIP. For illustrative purposes, data are expressed as median, mean ± SD, where appropriate.

Results: 155 patients underwent robotic pancreaticoduodenectomy 2012-18, with 88% occurring in 2015-18. Predicted outcomes were like outcomes reported in NSQIP (Table). Actual outcomes were often superior to predicted outcomes and outcomes reported in NSQIP (e.g., rates of complications, serious complications, patients returned to OR, SSI, DVT, and readmission and LOS) (Table). 27 (17%) patients had conversions to ‘open’ operations, generally due to failure to progress (often due to morbid obesity) or need for major vascular resection/reconstruction; only 2 (4%) of the last 55 robotic operations were converted to ‘open’. Robotic operations took 420, 428±108 minutes; blood loss was 150, 211±174 ml. Biliary fistulas occurred in 3%; pancreatic fistulas occurred in 9%. 6% died perioperatively, 5 patients due to cardiac deterioration and 5 patients due to pneumonia; only 1 patient died after pancreaticoduodenectomy completed robotically.

Conclusions: Our patients undergoing robotic pancreaticoduodenectomy were like patients reported in NSQIP; they were not a select group. Their outcomes after robotic pancreaticoduodenectomy are like or better than predicted outcomes or national data with the conventional ‘open’ approach. Our mortality was high because of preoperative ill-health and cardiac risk. While we believe our results will continue to improve, the robotic approach is the future of pancreaticoduodenectomy.
### Predicted vs Actual Outcome

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Predicted Outcome</th>
<th>Actual Outcome</th>
<th>NSQIP Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 155</td>
<td>N = 155</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious Complication</td>
<td>26%</td>
<td>9%*X</td>
<td>26%</td>
</tr>
<tr>
<td>Any Complication</td>
<td>31%</td>
<td>14%*X</td>
<td>30%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Cardiac Complication</td>
<td>3%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>SSI</td>
<td>19%</td>
<td>5%*X</td>
<td>18%</td>
</tr>
<tr>
<td>UTI</td>
<td>3%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>3%</td>
<td>0%*</td>
<td>2%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>2%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Readmission</td>
<td>16%</td>
<td>7%*X</td>
<td>16%</td>
</tr>
<tr>
<td>Return to O.R.</td>
<td>5%</td>
<td>0%*X</td>
<td>5%</td>
</tr>
<tr>
<td>Length of Stay (LOS)</td>
<td>10, 10±2 days</td>
<td>5, 8±8 days*</td>
<td>N/A</td>
</tr>
<tr>
<td>Death</td>
<td>2%</td>
<td>6%*O</td>
<td>2%</td>
</tr>
<tr>
<td>Discharge to Nursing or Rehab</td>
<td>16%</td>
<td>13%</td>
<td>10%</td>
</tr>
</tbody>
</table>

* = < predicted, p<0.05
^ = > predicted, p<0.05
x = < NSQIP, p<0.05
o = > NSQIP, p<0.05
28. OPERATIVE MORTALITY PREDICTION FOR PRIMARY RECTAL CANCER: AGE MATTERS

JoAnn Coleman*  
Chris D’Adamo*  
Joshua Wolf*  
Mark Katlic

Nita Ahuja  
David Blumberg*  
Vanita Ahuja*

Background: Age is a predictor of surgical outcomes in patients with rectal cancer. As the risk of colorectal cancer increases with age, the number of patients needing surgery has increased. Our study determines if operative mortality for primary rectal surgery can be accurately predicted and its relationship to age.

Methods: American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) database was used to analyze patients with primary rectal cancer undergoing proctectomy (2012-2015). Analysis of variance was performed to assess differences between age categories in predicted and actual mortality. Pearson correlation coefficients were computed to determine the accuracy of predicted and actual mortality. Logistic regression models were constructed to evaluate associations adjusted for key covariates.

Results: Age distribution of 9,289 patients was 18-64 (n=5,674), 65-79 (n=2,899), 80-89 (n=716). The overall correlation between predicted and actual mortality was low (r=0.20). The spectrum of correlation by age category was weakest to strongest: 18-64 (r=0.07), 80-89 (r=0.13) and 65-79 (r=0.25). Predicted mortality was overestimated in the 18-64 group and underestimated in both the 65-79 and 80-89 groups. Both predicted and actual mortality increased with age, even after adjustment for functional status, comorbidity and other covariates with adjusted logistic regression model (p<0.0001).

Conclusion: ACS-NSQIP mortality risk estimates appear to be poorly associated with actual mortality and the accuracy may differ between younger and older patients with primary rectal cancer. Goals of care discussion with the older patient regarding outcomes from rectal cancer surgery are indicated as there is an almost twice predicted mortality.

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* Correlation between predicted & actual mortality by age – 18-64: r=.07; 65-79: r=0.25; 80-89: r=0.14 p<0.0001
** Coefficients of predicted mortality x age category in logistic regression model of actual mortality (negative indicate mortality underestimate, positive indicate mortality overestimate) – 18-64: reference group; 65-79: 0.42; 80-89: -1.44
29. A2 TO B KIDNEY TRANSPLANTATION IN THE POST-KAS ERA: A 3-YEAR EXPERIENCE WITH ANTI-A TITERS, OUTCOMES AND COSTS

David Shaffer  Scott A. Rega*
Irene D. Feurer*  Rachel C. Forbes*

Introduction: In December 2014 the United Network for Organ Sharing (UNOS) updated the Kidney Allocation System (KAS) with a provision to allow centers to utilize blood group A2 kidneys for B recipients to improve access and reduce disparities in wait time for these recipients who are disproportionately African-American (AA). Despite the putative advantages, a recent UNOS analyses indicated only 4.5% of waitlisted B candidates were registered as eligible for A2 donor kidneys. Cited barriers to utilizing A2 to B transplants include: issues with titers thresholds and patient eligibility as well as increased costs. There is little published data on longitudinal post-transplant anti-A titers or outcomes of A2 to B deceased donor kidney transplants (DDKTx) since this allocation change. We report a 3-year experience of A2 to B DDKTx under KAS with a cost analysis.

Methods: A retrospective, single center, cohort analysis of 29 consecutive A2 to B and 50 B to B DDKTx from 12/2014-12/2017 was conducted. Eligibility for A2 to B DDKTx included at least two consecutive anti-A IgG titers <1:8. Pre- and post-operative anti-A titers were monitored prospectively. Outcomes included patient and graft survival, transplant wait time, serum creatinine and eGFR, hospital costs, post-transplant anti-A titers, and their change relative to pre-transplant. Data were analyzed using parametric and nonparametric tests, Kaplan-Meier survival methods, and mixed effects models of longitudinal post-transplant renal function that adjusted for KDPI and waiting time.

Results: AAs comprised 72% of the A2 to B and 60% of the B to B group and follow-up time averaged 22.3 and 21.9 months, respectively (both p>0.332). There were no between-group differences in mean wait time (58.8 vs 70.8 mos, p=0.151), creatinine (1.8 vs 1.3, p=0.085) or eGFR (47 vs 54, p=0.128) at 2 yrs. 1-yr graft (93.1% and 90.0%) and patient survival (93.1% vs 92.0%) did not differ (both p≥0.675). In A2 to B DDKTx, mean anti-A IgG titers were increased at discharge (p=0.001), 2 wks (p=0.054), 4 wks (p=0.038), and 3 mos (p=0.011) versus pre-transplant (Figure 1). There was no relationship between the change in titers at 4 weeks and post-transplant serum creatinine or eGFR (all p≥0.315). Pre-transplant anti-A titer screening added total costs of $76,550 over the 3 year study period, excluding additional coordinator time costs. A2 to B had significantly higher mean transplant total hospital costs ($114,638 vs $91,697, p<0.001) and hospital costs net organ acquisition costs ($42,356 vs $20,983, p<0.001).
Conclusions: Initial experience under KAS shows comparable outcomes for AAs with A2 to B versus to B to B DDKTx. Anti-A titers increased significantly post-transplant but did not adversely affect outcomes. Elevated post-transplant titers do not appear to signify allograft dysfunction and may be unnecessary to monitor. Hospital costs were significantly higher in the A2 to B group. Transplant programs, regulators, and payors will need to weigh improved access for minorities with increased costs. To the extent that increased costs constitute a barrier to its widespread adoption, alternative payments models should be considered for A2 to B DDKTx.

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REAL WORLD OUTCOMES OF TALIMOGENE LAHERPAREPVEC THERAPY: A MULTI-INSTITUTIONAL EXPERIENCE

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Amod A. Sarnaik*  
Mohammad Raheel Jajja*  
Jonathan S. Zager  
Frances Collichio*  
David W. Ollila  
Keith A. Delman

Background: Talimogene laherparepvec (TVEC) is a FDA-approved oncolytic herpes virus used to treat unresectable stage IIIB-IV metastatic melanoma via intralesional injection. We aim to determine the outcomes of commercially available TVEC in these patients.

Methods: We performed a multi-institutional, IRB-approved review of all patients who received TVEC at three centers from 10/2015–3/2018. Clinicopathologic characteristics, TVEC treatment data and outcomes were assessed.

Results: Ninety-four patients received TVEC, of which 88 patients had available treatment response data. Anatomic sites treated: 26 (30%) head and neck, 10 (11%) upper extremity, 11 (12%) torso and 41 (47%) lower extremity. Thirty-six patients (41%) received TVEC as first-line therapy. Side effects were mild, and self-limited, most commonly flu-like symptoms seen in 17 patients (19%). Mean follow-up was 7.4 months (range 1-22 months), with complete response (CR) in 31 (35%) and partial response (PR) in 13 (15%) patients. Of complete responders, 23 (74%) had no evidence of disease (NED) at last follow up and received on average 13 weeks (6 cycles) of therapy. Linear regression modeling demonstrated a strong correlation with a CR in patients receiving TVEC as first-line therapy (68%, p < 0.02).

Conclusions: Our data demonstrates TVEC has a promising complete response rate particularly when given as first-line therapy. TVEC is well tolerated and can be considered as first line therapy in patients with injectable stage IIIB/C and IV M1a disease.
<table>
<thead>
<tr>
<th>Primary Location</th>
<th>Compete Response</th>
<th>Partial Response</th>
<th>Stable Disease</th>
<th>Progression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and Neck</td>
<td>26 (30%)</td>
<td>1 (4%)</td>
<td>6 (23%)</td>
<td>5 (19%)</td>
</tr>
<tr>
<td>Upper Extremity</td>
<td>10 (11%)</td>
<td>4 (40%)</td>
<td>3 (30%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td>Torso</td>
<td>11 (12%)</td>
<td>4 (36%)</td>
<td>4 (36%)</td>
<td>2 (18%)</td>
</tr>
<tr>
<td>Lower Extremity</td>
<td>41 (47%)</td>
<td>9 (22%)</td>
<td>13 (32%)</td>
<td>17 (41%)</td>
</tr>
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</table>
BILATERAL NECK EXPLORATION FOR SPORADIC PRIMARY HYPERPARATHYROIDISM: UTILIZATION PATTERNS IN 5,597 PATIENTS UNDERGOING PARATHYROIDECTOMY IN THE COLLABORATIVE ENDOCRINE SURGERY QUALITY IMPROVEMENT PROGRAM

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Tracy S. Wang* Carmen C. Solórzano
Nancy D. Perrier

For many surgeons, minimally invasive (focused) parathyroidectomy has become the preferred approach for the management of sporadic primary hyperparathyroidism (spHPT). This study describes utilization patterns of bilateral neck exploration (BE) by endocrine surgeons participating in the Collaborate Endocrine Surgery Quality Improvement Program (CESQIP).

Methods: Using the CESQIP parathyroid dataset (2014-2017), utilization trends, demographic and clinical characteristics of patients undergoing BE vs. focused vs. focused-to-converted parathyroidectomy were compared. Preoperative, intraoperative and postoperative variables were also analyzed.

Results: Among 5,597 patients who underwent initial parathyroidectomy for spHPT, BE was utilized in 2,253 (40%) of which 613 (11%) were converted procedures (Table). Patients undergoing BE were older and more likely female. Ultrasound (87%), Sestamibi (66%) and CT scans (20%) were commonly utilized. Glands were highly localized. IoPTH was used in >90%. Operative time >2hrs was more likely in BE (16%) and converted (30%) vs. focused (3%) procedures. Two or more glands were removed in 57% of BE cases. Outpatient procedures were more common in focused cases; ER visits, readmissions and complications were more likely in BE and converted cases. Concern for failure and lack of ioPTH decrease was significantly more common in BE and converted cases.

Conclusions: This is the first analysis of parathyroidectomy utilization trends by high-volume endocrine surgeons in CESQIP. BE is a highly utilized approach (40%) and conversion from focused to BE was observed in 11% of cases despite preoperative localization. BE remains a complex and frequently utilized procedure and surgeons intending to perform parathyroid surgery should be adequately trained and adept at BE.

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<table>
<thead>
<tr>
<th>Variable</th>
<th>Focused N=3,344</th>
<th>BE N=1,640</th>
<th>Focused to converted N=613</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>61 (53,69)</td>
<td>63 (54,69)</td>
<td>63 (56,70)</td>
<td>0.001</td>
</tr>
<tr>
<td>Female gender</td>
<td>2,548 (76%)</td>
<td>1,269 (77%)</td>
<td>439 (80%)</td>
<td>0.067</td>
</tr>
<tr>
<td>Imaging</td>
<td>3,230 (97%)</td>
<td>1,545 (94%)</td>
<td>610 (99%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Localized gland(s)</td>
<td>3,136 (97%)</td>
<td>1,112 (72%)</td>
<td>573 (94%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ioPTH utilized</td>
<td>3,137 (94%)</td>
<td>1,494 (91%)</td>
<td>582 (95%)</td>
<td>0.001</td>
</tr>
<tr>
<td>Operative Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 hour</td>
<td>2,041 (61%)</td>
<td>524 (32%)</td>
<td>73 (12%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>1-2 hours</td>
<td>1,211 (36%)</td>
<td>848 (52%)</td>
<td>357 (58%)</td>
<td></td>
</tr>
<tr>
<td>2-3 hours</td>
<td>71 (2%)</td>
<td>229 (14%)</td>
<td>153 (25%)</td>
<td></td>
</tr>
<tr>
<td>&gt;3 hours</td>
<td>21 (1%)</td>
<td>39 (2%)</td>
<td>30 (5%)</td>
<td></td>
</tr>
<tr>
<td>Two or more glands removed</td>
<td>178 (5%)</td>
<td>933 (57%)</td>
<td>402 (66%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Outpatient</td>
<td>2,287 (75%)</td>
<td>768 (51%)</td>
<td>305 (54%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ER visit (n=5113)</td>
<td>94 (3%)</td>
<td>43 (3%)</td>
<td>31 (6%)</td>
<td>&lt;0.007</td>
</tr>
<tr>
<td>Readmission (n=5113)</td>
<td>24 (0.8%)</td>
<td>22 (1.5%)</td>
<td>12 (2%)</td>
<td>0.008</td>
</tr>
<tr>
<td>Complications (n=5583)</td>
<td>29 (0.9%)</td>
<td>43 (2.9%)</td>
<td>12 (2.3%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>&gt;50% drop ioPTH at end of case</td>
<td>2,990 (99%)</td>
<td>1,400 (95%)</td>
<td>533 (93%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Concern for failure (n=3187)</td>
<td>22 (1%)</td>
<td>33 (4%)</td>
<td>14 (5%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Surgeon performs ≥50 parathyroidectomies per year</td>
<td>2,326 (67%)</td>
<td>1,268 (77%)</td>
<td>465 (76%)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
INTRODUCTION: Pancreatic cancer remains the third leading cause of cancer related deaths. Though extent of lymph node (LN) resection is still debated, the log of the ratio (LODDS) of positive LNs (PLN) to negative LNs has been shown to be a strong indicator of survival. We hypothesize that we may derive an optimal number of lymph nodes examined (TLN), based on the LODDS distribution.

METHODS: In this NCDB retrospective study of surgically resected pancreatic adenocarcinoma (2010-2015), we examined PLN, TLN, and the log of the ratio of PLNs to negative LNs. To determine an optimal TLN examined to detect N1 disease, LODDS distribution was calculated for positive LN (N1) group vs negative LN (N0) group. Using the LODDS distribution of N1 cases, TLN cutoffs were calculated to encompass 90-95% of the N1 group.

RESULTS: Of the total 19,872 patients included in this study, 32.3% had surgery only while 67.7% underwent adjuvant therapy. Of these, 5958 (30%) of patients had N0 disease while 13,914 (70%) had N1 disease. To ensure all positive lymph nodes are resected in 90-95% of the N1 group base on LODDS distribution, the minimum number of LN examined is 19 (LODDS -2.46) to 25 (LODDS -2.73) respectively.

CONCLUSIONS: Though many studies have suggested 11-17 LNs for adequate LN sampling in pancreatic cancer, our findings suggest that at least 19 total LN examined are required to ensure N0 disease. This is a novel determination to determine the minimum number of LN resected to identify LN positive disease.

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LODDS Distribution by Positive Lymph Node Status in Surgically Resected Pancreatic Cancer

90% of N1
PROSPECTIVE TRIAL OF NEAR INFRARED FLUORESCENT LYMPH NODE MAPPING WITH INDOCYANINE GREEN IN BREAST CANCER PATIENTS

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Zahraa Al-Hilli*  
Chao Tu*  
Courtney Yanda*  
Diane Radford*  
Stephen R. Grobmyer

Background: Near infrared (NIR) fluorescence imaging is an emerging modality which can enable real-time image-guided surgery. Indocyanine green (ICG) is a FDA approved, inexpensive and widely available NIR dye. We hypothesized that axillary lymphatic mapping with ICG is equivalent to lymphatic mapping with technetium 99m (Tc-99m) in breast cancer patients.

Methods: Breast cancer patients (cT1-2,N0) were prospectively enrolled. Patients underwent lymphatic mapping with Tc-99 pre-operatively and ICG mapping intra-operatively (0.8cc). Sentinel lymph node (SLN) biopsy was guided by NIR camera and gamma probe. Rate of failed mapping, number of SLNs identified and rate of identifying pathologically positive SLNs was compared between the 2 techniques. p<0.05 was considered statistically significant.

Results: Eighty-four female patients were enrolled (mean age=59). Mean transit time from ICG injection in the breast to localization in the axilla was 5 minutes (range, 2-10). No adverse reactions to ICG were noted. Rate of failed mapping was 1.2% for ICG and 4.8% for Tc-99m (p=0.37). Mean number of SLNs identified with ICG and Tc-99m was 1.9 and 1.6 respectively (p<0.05). Pathologically positive SLNs were identified in 16 patients (19%). Excluding 1 patient with dual failed mapping, 17 positive SLNs were identified in 15 patients (100% identified by ICG and 94% identified by Tc-99, p=0.99).

Conclusions: ICG with NIR fluorescence imaging can be safely and efficiently used for real time intra-operative lymphatic mapping in breast cancer patients. ICG performs similarly to Tc-99m in regards to the number of SLNs identified, rate of failed mapping, and identification of pathologically SLNs.

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Introduction: Enhanced recovery after surgery (ERAS) protocols following ventral hernia repair (VHR) focus on opioid reduction. The routine use of epidural analgesia for post-operative pain has been a mainstay of these protocols; however, concern has been raised for extending the length of stay with their use. In an effort to reverse this, our protocol has been revised to include a transversus abdominis plane (TAP) block instead of epidural analgesia. We hypothesize this modification reduces length of stay (LOS) and lowers opioid usage in VHR.

Methods: All patients at our institution undergoing open VHR were recorded prospectively in the Americas Hernia Society Quality Collaborative (AHSQC) database. All patients receiving either TAP block or epidural between Feb 2016 and current were identified, and additional review performed to quantify opioid use in morphine milligram equivalents (MME). Primary outcomes were LOS and opioid use.

Results: Epidural analgesia was used in 172 patients, and TAP block in 74. There were no significant comorbidity differences between groups. TAP group had a slightly higher BMI (33.6kg/m² v 28.3kg/m²), and slightly smaller hernias (8.8cm v 10.8cm). There was no difference in 30-day surgical site infection (SSI). Hospital length of stay was significantly shorter with TAP block (2.4 v 4.5 days; p<0.001). Total MME requirements for patients receiving TAP block were lower than those with epidural over POD 1 and 2 (mean 40 v 54.1 MME, p=0.033 and 36.1 v 52.5 MME, p=0.018) [Table 1].

Conclusion: The use of TAP block significantly reduces LOS and decreases opioid dose requirements in the early post-operative period compared to epidural analgesia.

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<table>
<thead>
<tr>
<th></th>
<th>Tap</th>
<th>Epidural</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>74</td>
<td>172</td>
<td></td>
</tr>
<tr>
<td>LOS (days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>2.4 ± 2.8</td>
<td>4.5 ± 3.0</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>2 (1,3)</td>
<td>4 (3,5)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>POD 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>18.2 ± 12.9</td>
<td>23.6 ± 26.0</td>
<td>0.200</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>15 (8-23)</td>
<td>15 (10-21)</td>
<td>0.668</td>
</tr>
<tr>
<td>POD 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>40.0 ± 29.1</td>
<td>54.1 ± 45.8</td>
<td>0.033*</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>30 (20-48)</td>
<td>40 (15-74)</td>
<td>0.188</td>
</tr>
<tr>
<td>POD 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>36.1 ± 31.7</td>
<td>52.5 ± 48.6</td>
<td>0.018*</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>30 (15-46)</td>
<td>38 (15-68)</td>
<td>0.060</td>
</tr>
</tbody>
</table>

*Denotes statistically significant result
DUAL KIDNEY TRANSPLANTS FROM DONORS AT THE EXTREMES OF AGE REDUCE DELAYED GRAFT FUNCTION AND SUCCESSFULLY EXPAND THE LIMITED DONOR POOL

Jeffrey Rogers
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Giuseppe Orlando*
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Amber M. Reeves-Daniel*
Colleen L. Jay*
Michael D. Gautreaux*
William Doares*
Scott A. Kaczmorski*
Robert J. Stratta

Introduction: Historically, kidneys from donors at the extremes of age have been considered as marginal organs for kidney transplantation (KT) because of concerns regarding early technical complications and long-term functional outcomes. The study purpose was to analyze outcomes in recipients of pediatric dual en bloc (EB) kidneys from small pediatric donors (SPDs, age ≤ 3 years) and dual KTs (DKTs) from adult marginal deceased donors (MDDs) in the context of the Kidney Donor Profile index (KDPI).

Methods: Single center retrospective review of dual EB KTs from SPDs ≤ 3 years of age and DKTs from adult MDDs. Recipient selection included primary transplant, low BMI, low immunologic risk, and informed consent. All patients (pts) received depleting antibody induction with FK/MPA/± prednisone.

Results: From 2002-2015, we performed 34 dual EB and 72 adult DKTs. Mean donor ages were 17 months SPD and 60 years MDD, mean donor weights were 11.0 kg SPD and 75.9 kg MDD, and mean donor serum creatinine (SCr) levels were 0.37 SPD and 1.3 mg/dl MDD. Mean cold ischemia times were 21.0 SPD and 26.5 hours MDD and mean KDPIs were 73% SPD and 83% MDD. Adult DKT recipients were older (mean age 38.0 EB and 59.6 years DKT) and had shorter waiting times (mean 25 EB and 12 months DKT). With a mean follow-up of 7.5 years, actual patient (91% PEB and 61% DKT) and graft survival (GS, 73.5% PEB and 43% DKT) rates were higher in PEB compared to DKT. Death-censored kidney GS rates were 78% PEB and 58.5% DKT. Delayed graft function (DGF) rates were 12% EB and 25% DKT whereas the incidences of DGF in single KTs from SPDs and adult non-MDDs were 20% and 32%, respectively. Mean 2-year SCr levels were 1.1 EB and 1.5 mg/dl DKT whereas 2-year GFR levels were 75 EB and 51 ml/min/1.73 m² DKT. Based on actual 5-year GS rates, the adjusted KDPIs for
dual PEB and DKTs were <1% and 60%, respectively. EB KT survival outcomes from SPDs were comparable to concurrent living donor KTts and superior to standard criteria donor (SCD) single KTts at our center whereas survival outcomes following DKT were comparable to concurrent expanded criteria donor (ECD) single KTts although renal function was comparable to SCD single KTts and superior to ECD single KTts.

Conclusions: Excellent mid-term outcomes are associated with either dual EB or adult DKTs, which may expand the limited donor pool and prevent kidney discard at the extremes of donor age. The KDPI is not accurate for predicting outcomes from either dual EB from SPDs or DKT from adult MDDs, which may prevent centers from accepting these organs for KT.

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