CONTINUING MEDICAL EDUCATION CREDIT INFORMATION

Accreditation
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American College of Surgeons and the Southern Surgical Association. The American College of Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA Category 1 Credits™
The American College of Surgeons designates this live activity for a maximum of 18.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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 9
8:30am  Morning Session
        Business Meeting
            1.  President
            2.  Secretary
            3.  Chair, Committee
                on Arrangements
        Presidential Address
        Presentation of Papers 1 – 5

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

Tuesday, December 10
8:30am  Morning Session
        Presentation of Papers 14 – 21

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

Wednesday, December 11
8:30am  Morning Session
        Presentation of Papers 30 – 35

11:30am  Business Meeting
            1.  President
            2.  Audit Committee
            3.  Shipley Award for 2018

        Noon  Meeting Adjournment
SOCIAL EVENTS

Sunday, December 8

12-5pm  Golf Tournament (weather permitting)
        Hosted by: Dr. Martin Croce
        Location: Old Course-Meet at Casino Pro Shop

12-4pm  Fly Fishing Trip
        Location: Allegheny Outfitters

1pm-    Culinary Program: Farm Cheese and Wine
2:30pm  Location: Crystal Room

1-4pm   Women’s Tennis (weather permitting)
        Hosted by: Dr. Cynthia Downard
        Location: The Homestead Tennis Courts

1-4pm   Men’s Tennis (weather permitting)
        Hosted by: Dr. Bryan Clary
        Location: The Homestead Tennis Courts

1-5pm   Pickle Ball- Racquet, Balls, Court time
        Hosted by: Dr. Cynthia Downard
        Location: The Homestead Tennis Courts

2-5pm   Skeet Shoot Tournament
        Hosted by: Mr. David Britt
        Location: Shooting Club

4:30-   Chocolate and Bourbon Pairing
5:30pm  Location: Chesapeake Room
Monday, December 9

8-9am  Yoga  
Location: Mt. Vernon Room

10am-  History Tour  
11am  Location: South Parlor

10am-  Spouses’ Coffee/Tea  
12:30pm  Hosted by: Mrs. Beth McMasters  
Location: Crystal Room

11am-  Archery  
12pm  Location: Allegheny Outfitters

1-2pm  One Hour Trail Ride  
Location: Equestrian Center

1-2pm  Gorge Hike  
Location: Allegheny Outfitters

2pm  Bridge  
Hosted by: Mrs. Gail Meredith  
Location: Tower Suite

3-4pm  Mixology Class  
Location: Lexington Room

5:30-  New Members Reception  
7pm  Location: Commonwealth Room  
(Members and guests are invited)
Tuesday, December 10

7:00- Women’s Breakfast  
8:30am Location: Commonwealth Room

8-9am Yoga  
Location: Mt. Vernon Room

10am The Southern Surgical Book Discussion:  
Carolynn’s Club: Where the Crawdads Sing  
A Novel, by Delia Owens  
Discussion Leader: Mrs. Jane Sharp  
Location: Commonwealth Room

10am- History Tour  
11am Location: Jefferson Parlor

11am- Archery  
12pm Location: Allegheny Outfitters

12:30- Falconry  
1:30pm Location: The South Parlor

1-2pm Culinary Demo: Secrets of Sous Vide  
Location: Empire Room

1-2pm Gorge Hike  
Location: Allegheny Outfitters

2-3pm Bridge  
Hosted by: Mrs. Gail Meredith  
Location: Tower Suite
Tuesday, December 10 (Continued)

3-4pm  Sip & Paint
       Location: Lexinton Room

4-5pm  Sparkling Wine Tasting
       Location: Crystal Room

6:30-  Presidential Reception (Black Tie)
7:30pm Location: Mt. Vernon/Stratford Room

7:30-  Association Dinner and Dance (Black Tie)
11pm  Location: Grand Ballroom
Wednesday, December 11

12:30- President’s Buffet Luncheon
1:30pm Location: Empire/Crystal Room
(Members and guests are invited)
Background: Liver-directed hepatic arterial therapies are associated with improved survival and effective symptom control for patients with unresectable neuroendocrine liver metastases (NELM). Short and long outcomes between trans arterial chemoembolization (TACE) or selective internal radiation therapy (SIRT) with yttrium-90 (Y-90) have not been previously investigated.

Methods: A retrospective review of all patients with NELM at two academic medical centers undergoing liver- directed hepatic arterial therapy from 2000-2018 was performed. Postoperative morbidity, radiographic response according to RECIST criteria, and long-term outcomes were compared between patients who underwent TACE versus SIRT.

Results: Among 248 patients with NELM, 197 (79%) received TACE while 51 (21%) received SIRT. While patients who underwent TACE were more likely to experience carcinoid syndrome, have larger tumors, and have higher chromogranin A levels, there was no difference in tumor differentiation, primary site, bilobar disease, or synchronous presentation. Nearly all SIRT treatments (92%) were performed as an outpatient while 99% of TACE patients spent at least one night in the hospital. There were no differences in overall complications (SIRT 13.7% vs TACE 22.6%, p=0.17), grade III/IV (5.9% vs 9.2%, p=0.58) complications, or 90-day mortality. The disease control
rate (DCR) on first post-treatment imaging (RECIST partial/complete response or stable disease) was greater for TACE compared to SIRT (97 vs 85%, p=0.0057). However, there was no difference in median OS (35.9 months vs 50.1 months, p=0.3) or PFS (15.9 months vs 19.9 months, p=0.37) (Figure).

**Conclusions:** In the largest comparative series reported, both TACE and SIRT with Y-90 are safe and effective liver-directed therapies for unresectable NELM. Although SIRT was associated with a shorter length of hospital stay, TACE demonstrated improved short term DCR, and both resulted in comparable long-term outcomes.

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2. VIRTUAL CROSSMATCHING IN KIDNEY TRANSPLANTATION: THE WAIT IS OVER….

Prabhakar Baliga    Satish Nadig*
Vinayak Rohan*    Derek Dubay*
Nicole Pilch*    David Taber*
Omar Moussa*

Background: Flow cytometric crossmatching (FCXM) is currently the method of choice for most transplant programs prior to kidney transplantation. Physical crossmatching is costly, resource intensive and time consuming. In July of 2017, our program implemented the virtual cross-match, without a prospective physical cross-match, for the majority patients in the setting of a new kidney allocation system implemented by UNOS. The aim of this process improvement project was to determine the impact of programmatic implementation of virtual cross-matching on kidney transplant outcomes.

Methods: A retrospective review, using center specific UNOS Standard Transplant Analysis and Research files, was conducted to determine if virtual cross-matching could reduce cold ischemia time (CIT). Secondary outcomes included the overall incidence of delayed graft function, defined as the need for dialysis within the first 7 days post-transplant and 1-year patient and allograft failure. Patients transplanted prior to changes in allocation (12/2014), patient with <1- year follow-up, multiorgan and pediatric recipients were excluded.

Results: A total of 825 patients received a kidney transplant between 12/1/2014 and 7/1/2018. A total of 93 patients were excluded (n=69 multiorgan, n=24 pediatric). Table 1A illustrates differences between pre and post-implementation. Overall CIT times were decreased between groups and more import organs were used with less DGF. There was no hyperacute rejection There was no difference in 1-year patient and graft survival. Table 1B has a breakdown of differences between local and import CITs.

Conclusions: Overall virtual cross-matching, without a prospective physical crossmatch, improved CIT times and reduced DGF rates without adversely impacting patient or allograft survival.

Medical University of South Carolina, Charleston, SC, baligap@musc.edu
<table>
<thead>
<tr>
<th>Table 1A: Overall Pre and Post-Implementation Observations</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Cold Ischemia Time (hrs, avg±stdev)</td>
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<tr>
<td></td>
</tr>
<tr>
<td>DGF</td>
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<tr>
<td>Graft Failure within 1 year</td>
</tr>
<tr>
<td>Patient Death within 1 year</td>
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<tr>
<td>Import organs</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 1B: Cold Ischemia Times</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Cold Ischemia Times- Local Donor</td>
</tr>
<tr>
<td>Cold Ischemia Times- Import Donor</td>
</tr>
</tbody>
</table>
3. DEVELOPMENT AND VALIDATION OF A LABORATORY RISK SCORE (LABSCORE) TO PREDICT OUTCOMES FOLLOWING RESECTION FOR INTRAHEPATIC CHOLANGIOCARCINOMA

Diamantis I. Tsilimigras*  George A. Poultsides*  B. Groot Koerkamp*
Rittal Mehta*  Shishir K. Maithel*  Todd W. Bauer*
Anghela Z. Paredas*  Hugo P. Marques*  Itaru Endo*
Fabio Bagante*  Guillaume Martel*  Jordan Cloyd*
Luca Aldrighetti*  Carlo Pulitano*  Aslam Ejaz*
Matthew Weiss*  Feng Shen*  Timothy M. Pawlik
Sorin Alexandrescu*  Oliver Soubrane*

Introduction: Estimating prognosis in the preoperative setting is challenging as most survival risk scores rely exclusively on postoperative factors. We sought to develop a composite score that incorporated preoperative liver, blood, nutritional and inflammatory markers to predict long-term outcomes following resection of intrahepatic cholangiocarcinoma (ICC).

Methods: Patients who underwent hepatectomy for ICC between 1990-2016 were identified using an international multi-institutional database. Clinico-pathologic factors were assessed using bivariate and multivariable analysis and a prognostic model to estimate overall survival (OS) based only on preoperative laboratory values (LabScore) was developed and validated.

Results: Among 671 patients, median and 5-year OS were 40.9 months (IQR: 32.7-49.2) and 41.7%, respectively. On multivariable analysis, laboratory values associated with OS included carbohydrate antigen (CA) 19-9 (HR=1.25, 95%CI 1.15-1.35), neutrophil-to-lymphocyte ratio (NLR)(HR=1.09, 95% CI 1.04-1.12), platelet count (PLT)(HR=1.01, 95%CI 1.00-1.01) and albumin (HR=0.75, 95%CI 0.57-0.99). A weighted LabScore was constructed based on the formula: [10.19 + 2.2*lnCA19-9 + 0.77*NLR + 0.02* PLT -2.83*albumin]. Patients with a LabScore of 0-9 (n=111), 10-19 (n=385) and >20 (n=175) had an incrementally worse 5-year OS of 81.5%, 47.1% and 14.8%, respectively (p<0.001, Figure). The model demonstrated good performance in both the test (AUC 0.701) and validation cohorts (AUC 0.612), as well as outperformed individual laboratory markers, the prognostic nutritional index (AUC 0.579) and the 8th edition of AJCC staging (AUC 0.586).
Conclusions: A preoperative LabScore was able to predict long-term outcomes of patients following resection for ICC better than AJCC staging. Composite laboratory scores may provide an easy-to-use and helpful prognostic tool in risk stratifying patients with ICC.

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4. POST PANCREATECTOMY DIABETES INDEX (PDI): A VALIDATED SCORE PREDICTING DIABETES DEVELOPMENT FOLLOWING MAJOR PANCREATECTOMY

Daniel W. Maxwell*    Chao Zhang*
Mohammed Raheel Jajja*   Juan M. Sarmiento
Rodolfo J. Galindo*

Background: Literature is varied regarding risk-factors associated with diabetes development following major pancreatic resection. The aim was to develop and validate a scoring index which preoperatively predicts the development of diabetes following pancreatectoduodenectomy and distal pancreatectomy.

Methods: In this prospective study, perioperative fasting and postprandial (OGTT) plasma glucose, HbA1c, insulin, and c-peptide were measured in select-consecutive patients undergoing pancreatectoduodenectomy and distal-pancreatectomy by the senior author from 2007-2018. American Diabetes Association definitions were used for glycemic classifications. Statistical analyses included: Multivariate generalized estimated equation for factor identification and variable weighting; area under the receiver operating curve (ROC) c-statistic for predictive ability and; survival analysis risk score grouping.

Results: Of 1083 included patients with pre-operative normoglycemia (253 ; 23.4%), pre-diabetes (362 ; 33.4%), and diabetes (468 ; 43.2%), the overall postoperative incidence of each diabetic class at 120 months was 152 (14.0%), 466 (43.0%), and 465 (42.9%), respectively. The development and validation groups included n=1023 and n=60 patients, respectively. Five factors were identified predicting diabetes development with a total possible score of 8. The C-statistics for development and validation groups were of 0.727 (CI 0.696-0.759, p<0.001) and 0.823 (CI 0.718-0.928, p<0.001), respectively. At a cut point of 3 (sensitivity=0.691, specificity=0.644) the PDI independently predicted diabetes in development (OR4.298, RR2.486, CI 1.238-5.704, p<0.001) and validation (OR6.970, RR2.768, CI 2.182-22.261, p<0.001) groups. The PDI similarly predicted pre-diabetes in development (OR1.961, RR1.325, CI 1.202-2.564, p<0.001) and validation (OR4.255, RR1.798, CI 1.247-14.492, p=0.021) groups.

Conclusions: The Post-pancreatectomy Diabetes Index predicts the development of diabetes and pre-diabetes in patients undergoing major pancreatectomy utilizing routine endocrine laboratories and pre-surgical data.
Table 1. PDI Scoring Criteria

<table>
<thead>
<tr>
<th>Variable</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td><strong>Endocrine evaluation</strong></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1c or eA1c, %</td>
<td></td>
</tr>
<tr>
<td>&lt;6.4</td>
<td>0</td>
</tr>
<tr>
<td>5.5-5.9</td>
<td>1</td>
</tr>
<tr>
<td>6.0-6.4</td>
<td>2</td>
</tr>
<tr>
<td>6.5-6.9</td>
<td>3</td>
</tr>
<tr>
<td>&gt;7.0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
</tr>
<tr>
<td>BMI ≥30 kg/m2</td>
<td>1</td>
</tr>
<tr>
<td>Age ≥65 years-old</td>
<td>1</td>
</tr>
<tr>
<td><strong>Procedure</strong></td>
<td></td>
</tr>
<tr>
<td>Distal pancreatectomy</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>8</td>
</tr>
</tbody>
</table>
Background: Controversy remains over appropriate mesh selection during ventral hernia repair (VHR) in a contaminated field. Fear of mesh infection has led to increased use of biologic and absorbable synthetic mesh rather than permanent synthetic mesh in these cases. We report the safety and efficacy of permanent synthetic mesh during contaminated VHR.

Methods: Retrospective review of our database identified all cases of contaminated VHR from 7/2007 to 5/2019. Student’s t-test and Wilcoxon rank-sum were used to analyze continuous variables, and discrete variables with Fisher’s or Kruskal-Wallis test.

Results: There were 541 contaminated cases: 245 clean-contaminated, 214 contaminated and 82 dirty cases. Suture repair was performed in 46 patients, biologic mesh used in 38, absorbable synthetic mesh in 55, and permanent synthetic mesh in 402. Mesh was extraperitoneal in 97% of cases. Incidence of surgical site infection (SSI) in each group was 17.4%, 36.8%, 32.7% and 14.2% respectively (p<0.001). Multivariate analysis showed no effect of mesh selection on SSI risk. Mesh was removed in 7 patients; 5 permanent synthetic (1.2%), one absorbable synthetic (1.8%) and one biologic (2.6%). Four were mesh-specific complications, and the remaining were removed during exploration for indications unrelated to the mesh. At a median follow-up of 30.2 months, recurrence occurred in 15.2% of patients and was significantly lower with permanent synthetic mesh.

Conclusions: Permanent synthetic mesh placed in an extraperitoneal position is not only safe for VHR in a contaminated field, but it confers a significantly lower rate of SSI and recurrence when compared to biologic or bioabsorbable meshes.

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rstratta@wakehealth.edu
<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>None</th>
<th>Permanent Synthetic</th>
<th>Absorbable Synthetic</th>
<th>Biologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>541</td>
<td>46</td>
<td>402</td>
<td>55</td>
<td>38</td>
</tr>
<tr>
<td>LOS, Median (IQR)</td>
<td>5 (3-7)</td>
<td>5 (2.10)</td>
<td>5 (3, 7)</td>
<td>6 (4, 10)</td>
<td>5 (3, 9)</td>
</tr>
<tr>
<td>Readmission, N (%)</td>
<td>83 (15.34)</td>
<td>5 (10.87)</td>
<td>69 (17.16)</td>
<td>4 (7.27)</td>
<td>5 (13.16)</td>
</tr>
<tr>
<td>Reoperation, N (%)</td>
<td>118 (21.81)</td>
<td>9 (19.57)</td>
<td>80 (19.9)</td>
<td>19 (34.55)</td>
<td>10 (26.32)</td>
</tr>
<tr>
<td>Recurrence, N (%)</td>
<td>82 (15.16)</td>
<td>13 (28.26)</td>
<td>42 (10.45)</td>
<td>17 (30.91)</td>
<td>10 (26.32)</td>
</tr>
<tr>
<td>Any SSI, N (%)</td>
<td>97 (17.93)</td>
<td>8 (17.39)</td>
<td>57 (14.18)</td>
<td>18 (32.73)</td>
<td>14 (36.84)</td>
</tr>
<tr>
<td>Superficial</td>
<td>65 (12.01)</td>
<td>3 (6.52)</td>
<td>64 (15.92)</td>
<td>13 (23.64)</td>
<td>12 (31.58)</td>
</tr>
<tr>
<td>Deep</td>
<td>24 (4.44)</td>
<td>2 (4.35)</td>
<td>18 (4.48)</td>
<td>2 (3.64)</td>
<td>2 (5.26)</td>
</tr>
<tr>
<td>Organ Space</td>
<td>24 (4.44)</td>
<td>1 (2.17)</td>
<td>11 (2.74)</td>
<td>9 (16.36)</td>
<td>3 (7.89)</td>
</tr>
<tr>
<td>Mesh removal</td>
<td>7 (1.29)</td>
<td>0 [0]</td>
<td>4 (1)</td>
<td>2 (3.64)</td>
<td>1 (2.63)</td>
</tr>
<tr>
<td>Follow-up Time (months)</td>
<td>55.0 ± 64.6</td>
<td>36.2 ± 36.9</td>
<td>46.6 ± 57.2</td>
<td>96.1 ± 71.2</td>
<td>107.8 ± 99.2</td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>30.2 (6.1, 82.8)</td>
<td>23.9 (6.1, 64.7)</td>
<td>21.3 (5.8, 65.4)</td>
<td>91.2 (43.8, 148.6)</td>
<td>63.3 (29.2, 184.2)</td>
</tr>
<tr>
<td>Median (IQR)</td>
<td></td>
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</table>
6. AGE-DEPENDENT ASSOCIATION OF OCCULT HYPOPERFUSION AND OUTCOME IN TRAUMA: A SINGLE-CENTER COHORT ANALYSIS OF 3,126 TRAUMA PATIENTS

Bryan Cotton  Charles E. Wade*
Gabrielle E. Hatton*  Lilian S. Kao*
Michelle K. McNutt*

Introduction: Occult hypoperfusion (OH), or global hypoperfusion with normal vital signs, is a risk factor for poor outcomes in elderly trauma patients. We hypothesized that OH is associated with worse outcomes than shock in both young and elderly trauma patients.

Methods: A single-center cohort study of adult (≥16 years) trauma patients from 2016 to 2018 with a base excess (BE) measured on arrival was performed. Perfusion states were defined as: Shock if HR>120 or SBP<90; OH if BE<-2, HR<120, and SBP>90; and normal for all others. Patients were stratified as young (<55 years) or elderly (≥55). Multivariable Bayesian logistic analyses were utilized to assess the relationship between arrival perfusion state and mortality or serious complication.

Results: Of 3,126 included patients, 855 were elderly. Rates of shock (33% and 31%) and OH (25% and 23%) were similar in young and elderly patients respectively. OH on arrival was associated with a higher risk of mortality or serious complication than normal perfusion regardless of age group (Table). Compared to shock, OH was associated with a RR 1.61 (95% CI 0.93-2.64) of poor outcome in the elderly and a RR 0.43 (95% CI 0.29-0.60) of poor outcome in younger patients. Findings were similar on sensitivity analysis excluding shock patients with BE ≥ -2.

Conclusions: In elderly, but not younger, patients, OH is associated with worse outcomes than shock. Although shock parameters may need to be redefined in the elderly, more attention is necessary to the diagnosis and treatment of all hypoperfused states in this age group.
## Risk of Mortality or Major Complication: Bayesian Multivariable Analysis

<table>
<thead>
<tr>
<th>Comparison of OH to Normal Perfusion</th>
<th>Young Patients</th>
<th>1.83 (1.14-2.97)</th>
<th>&gt;99%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Elderly Patients</td>
<td>1.77 (1.13-2.67)</td>
<td>&gt;99%</td>
</tr>
<tr>
<td>Comparison of OH to Shock</td>
<td>Young Patients</td>
<td>0.43 (0.29-0.60)</td>
<td>&lt;1%</td>
</tr>
<tr>
<td></td>
<td>Elderly Patients</td>
<td>1.61 (0.93-2.64)</td>
<td>95%</td>
</tr>
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</table>

Adjusted for age, sex, trauma type, and injury severity score, neutral prior utilized.
7. **NON-ADHERENCE TO STANDARD OF CARE FOR LOCALLY ADVANCED COLON CANCER AS A CONTRIBUTORY FACTOR FOR THE HIGH MORTALITY RATES IN KENTUCKY**

Zeta Chow*     Nancy Schoenberg*
Tong Gan*     Mark Dignan*
Quan Chen*     B. Mark Evers
Bin Huang*     Avinash S. Bhakta*

**Background:** Kentucky has one of the highest mortality rates in colon cancer despite dramatic improvements in screening. NCCN guidelines recommend surgery and adjuvant chemotherapy for locally advanced (stage IIb/ c and stage III) colon cancer (LACC). The purpose of this study was to determine the rate of non-adherence with current standard of care (SOC) and associated factors as possible contributors to mortality.

**Methods:** The Kentucky Cancer Registry (KCR) database linked with administrative health claims was queried for individuals (≥ 20 years) diagnosed with LACC from 2007-2012. Bivariate and logistic regression of non-adherence was performed. Survival analysis was performed with Cox regression and Kaplan-Meier plots.

**Results:** A total of 1390 patients with LACC were included. Approximately 40% of LACC patients were noted to be non-adherent to SOC with nearly all (99.4%) failing to receive adjuvant chemotherapy. After adjusting for all significant factors, we demonstrated factors associated with non-adherence included: age >75 years, stage III colon cancer, high Charlson comorbidity index (CCI 3+), low education level, Medicaid coverage, and disability (Table). Adherence to SOC is associated with a significant increase in the 5-year survival rate compared with non-adherence (59.1% vs 31.3%, respectively, p<0.0001).

**Conclusion:** Our study identified multiple factors associated with the failure of LACC patients to receive appropriate adjuvant chemotherapy, suggesting the need to focus on the SOC in specific populations. Non-adherence to current NCCN guidelines for LACC results in a lower survival rate and is likely a major contributor to the persistently high mortality rates in Kentucky.

*Markey Cancer Center, University of Kentucky, Lexington, KY, mark.evers@uky.edu*
<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Odds Ratio</th>
<th>95% CI</th>
<th>p-value</th>
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<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-49</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-64</td>
<td>0.89</td>
<td>0.42-1.87</td>
<td>0.7579</td>
</tr>
<tr>
<td>65-74</td>
<td>4.43</td>
<td>1.63-12.0</td>
<td>0.0036</td>
</tr>
<tr>
<td>&gt; 75</td>
<td>21.6</td>
<td>7.90-59.3</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td><strong>Stage</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Stage IIb/c</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage IIa/b</td>
<td>6.51</td>
<td>2.56-165.5</td>
<td>&lt;0.0001</td>
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<tr>
<td>Stage IIIc</td>
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*OR, odds ratio; CI, confidence interval; Ref, reference; High school education is categorized as a range of patients who completed high school: low (75.8-84.7%), moderate (85.1-91.8%), and high (92.1-94.8%). Large hospitals are defined as treating > 100 cancer cases per year; Academic hospitals include University of Kentucky and University of Louisville.
8. GENERAL SURGERY RESIDENT UTILIZATION OF ELECTRONIC RESOURCES: 15 MINUTES A DAY

Kevin J. Hancock*    Douglas S. Tyler
V. Susan Klimberg    Alexander Perez
Ravi S. Radhakrishnan

Background: General surgery resident performance on the American Board of Surgery In-Service Training Exam (ABSITE) has been used to predict American Board of Surgery (ABS) passage rates, selection for remediation programs, and ranking of fellowship applicants. We sought to identify electronic resource study habits of general surgery residents associated with successful test scores.

Methods: A single institution, retrospective review of general surgery resident use of two electronic study resources, TrueLearn (TL) and Surgical Council on Resident Education (SCORE), were evaluated for the 7 months prior to the 2019 ABSITE. Metrics included number of TL questions, TL percent correct, SCORE utilization, and a survey about reading sources. These metrics were evaluated in three ABSITE percentile groupings: ≥80th, 30th – 79th, and <30th.

Results: The ≥80th and 30th – 79th percentile groups scored higher on TL questions at 69% and 67.7% compared to 61.4% for the <30th percentile group (p<0.03). The ≥80th percentile group spent on average 14.6 min/day on SCORE compared to 5.0 min/day and 4.7 min/day for the 30th – 79th and <30th percentile group respectively (p<0.04). The ≥80th percentile group spent 34.8 min/session (77 sessions) compared to 19.2 min/session (49 sessions) and 20.7 min/session (43 sessions) in the 30th -79th and <30th percentile group respectively (p=0.009) (Figure).

Conclusions: We have identified metrics in two study resources, SCORE and TrueLearn, which can lead to superior performance. An average 15 minutes per day or spending 15 minutes longer per study session are tangible goals residents can strive to reach for improved ABSITE performance.

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9. ASSESSING MALNUTRITION BEFORE MAJOR ONCOLOGIC SURGERY: ONE SIZE DOES NOT FIT ALL

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Waddah B. Al-Refaie*
John H. Pemberton
Nicholas P. McKenna*

Katherine A. Bews*
Dorin T. Colibaseanu*
Elizabeth B. Habermann*

Background: Malnutrition is a well-established risk factor for adverse surgical outcomes. While there are multiple definitions for malnutrition, evidence of superiority of any one definition to assess preoperative risk is lacking. Therefore, to aid in identification of patients that might warrant prehabilitation we aimed to determine the optimal definition of malnutrition before major oncologic resection for six cancer types.

Methods: The ACS-NSQIP database was queried for patients undergoing elective major oncologic surgery from 2005-2017. Nutritional status was evaluated using the European Society for Parenteral and Enteral Nutrition (ESPEN) definitions, NSQIP’s variable for >10% weight loss over the prior 6 months, and the World Health Organization body mass index (BMI) classification system. Patients were then categorized into seven hierarchical nutrition categories: 1) “severe malnutrition” (BMI < 18.5 + weight loss), 2) “ESPEN 1” (BMI 18.5 to 20 (if age < 70) or 22 (age ≥70) + weight loss), 3) “ESPEN 2” (BMI < 18.5), 4) “NSQIP” (BMI> 20 (if age < 70) or 22 (age ≥70) and >10% weight loss), 5) “mild malnutrition” (BMI 18.5 to 20 (if age < 70) or 22 (age ≥70)), 6) “obese” (BMI ≥ 30), and 7) “no malnutrition.”

Results: 205,840 operations were identified (74% colorectal, 10% pancreatic, 9% lung, 3% gastric, 3% esophageal, and 2% liver). A minority (16%) of patients met criteria for malnutrition (0.6% severe malnutrition, 1% ESPEN 1, 2% ESPEN 2, 6% NSQIP, 6% mild malnutrition), 31% were obese, and the remaining 54% had a normal nutrition status. Mortality and major morbidity both varied significantly between the nutrition groups (both \( p<0.0001 \)). An interaction between nutritional status and cancer type was observed in the models for mortality and major morbidity (interaction term \( p<0.0001 \) for both) indicating the optimal definition of malnutrition varied by cancer type. In cancer-specific models, “severe malnutrition” was the strongest predictor of mortality and major morbidity for colorectal cancer and esophageal cancer, “ESPEN 1” was the strongest predictor of mortality and major morbidity for gastric cancer and lung cancer, and “NSQIP” was the strongest predictor of mortality in liver cancer (Figure).
Conclusions: Our unique finding is that the definition of malnutrition used to assess postoperative risk is specific to the type of cancer being treated. These findings can be used to enhance nutritional preparedness in the preoperative setting.

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10. IMPACTFUL HISTORY FIGURE: JUDGE FRANK MINIS JR.

Selwyn Vickers    L.D. Britt
Kirby Bland

Consistent with the impact of the Southern Surgical Association and its leaders and the 50th Anniversary of Martin Luther King Jr’s death being both locally relevant and nationally impactful, Frank Minis Johnson Jr. served in a similar way. In 1955, three seminal Civil Rights figures descended to Montgomery, Alabama. Two of which are well known, MLK Jr. and Rosa Parks, but the other, Judge Johnson, is arguably the most provocative. Born in 1918 in the free state of Winston County, Alabama, he is considered a prominent figure for legal transformation and is recognized for defense of the constitution, particularly in the Deep South. In his court, the Middle Federal District of Alabama, he adjudicated notable cases that defined Civil Rights and transformed the south through influence and rulings on segregation. In particular, his decree in Browder v. Gayle (1956) eliminated segregation of public transportation and Lewis v. Greyhound (1961) desegregated interstate transportation to protect the Freedom Riders. Lee v. Macon County (1963) allowed for the first statewide integration of schools and preceded George Wallace’s stand in the University of Alabama’s door. Finally, exercising the fundamental principle of proportionality, Williams v. Wallace (1965) reversed the George Wallace ruling which was intended to stop the Selma March and ultimately led to the Voting Rights Act of 1965. During Judge Johnson’s twenty-four-year term, not a single adjudicated trial was overturned, despite the vast majority being appealed to the Circuit or Supreme Courts. His notable decisions were transformative for the south and for America.

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Background: Decisions on who requires a simultaneous liver-kidney transplant (SLKT) have been controversial due to difficulty in predicting recovery of native renal function following liver transplantation (LT). UNOS guidelines established a “safety net” in 2017 providing prioritization on the kidney waitlist for patients with early and persistent renal failure after LT. However, historical evidence showed inferior survival for early kidney after liver transplant (KALT) compared with SLKT. Given limited KALT numbers to evaluate the efficacy of the “safety net”, we compared early KALT and SLKT survival in a post-MELD cohort to examine its potential merit.

Methods: Using national UNOS data, we compared SLKT, KALT, and LT only in adult patients who underwent whole deceased donor (DD) LT from 2002 to 2018. Early KALT was defined as 60-365 days between LT and subsequent kidney transplant (reflecting safety net listing criteria). Patient survival (PS) from time of LT was the primary outcome. SLKT patients who died within 60 days (n=880 or 9.8% of SLKT recipients during the study) were excluded to mitigate immortal time bias favoring KALT. Renal failure at time of LT was defined as serum creatinine >2.5 mg/dL or patient on dialysis.

Results: There were 6,773 SLKTs, 108 KALTs at 60-365 days (77% DD), 133 KALTs at 1-2 years (65% DD), 830 KALTs at >2 years (74% DD) following LT, and 11,501 LT only. There were no significant differences in PS rates for KALTs at 60-365 days (HR=0.59, 95%CI=0.34-1.01) or KALTs at 1-2 years (HR 0.75, 95%CI=0.52-1.08) compared with SLKTs adjusting for recipient age, race/ethnicity, gender, MELD, BMI, home/hospital/ICU status, prior LT, diabetes, and renal function (Figure 1A). KALTs at >2 years had improved PS compared with SLKTs (HR=0.39, 95%CI=0.33-0.46). PS rates were also equivalent for early KALTs excluding living donor (LD) compared to SLKTs (Figure 1B). Both SLKTs and early KALTs had higher PS rates compared with LT only in patients with renal failure (1 and 3 yrs PS: 84% and 71% for LT only, 91% and 83% for SLKT, and 97% and 92% for early KALT). There were a significantly decreased proportion of early KALTs in both African American (AA) and Hispanic
(Hisp) patients compared with SLKTs even after excluding LD (DD KALT 78% white, 8% AA, 11% Hisp vs SLKT 63% white, 16% AA, 17% Hisp, p=0.04.)

**Conclusions:** In this retrospective UNOS Registry analysis, early KALTs have equivalent survival compared to SLKTs both for all KALTs and for DD KALTs only, supporting the promise of the “safety net”. Historically, there is a racial/ethnic disparity in the proportion of patients undergoing early KALT even after excluding LD.

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Figure 1A: Patient survival for early KALTs (all – deceased and living donor) vs SLKTs

Early KALT (60-365 days) vs SLK: unadjusted (logrank) p=0.03, adjusted (cox) p=0.052

Figure 1B: Patient Survival for early KALTs (deceased donor only) vs SLKTs

Early KALT (60-365 days) vs SLK: unadjusted (logrank) p=0.26, adjusted (cox) p=0.31
Introduction: Gun violence remains a significant public health problem that is both understudied and underfunded, plagued by inadequate or inaccessible data sources. Over the years, numerous trauma centers have attempted to utilize local registries to study single institutional trends, however, this approach limits generalizability to our national epidemic. In fact, even easily accessible, health-centered data from the Centers for Disease Control and Prevention, because they are limited to only those enrolled states, lack national relevance. Thus, we sought to examine how publicly available, law enforcement data from all 50 states might complement our understanding of circumstances and demographics surrounding national firearm deaths and help forge the first step in partnering law enforcement with trauma centers.

Methods: All homicides occurring in the United States over a 37-year period ending in 2016 were analyzed. Primary data files were obtained from the Federal Bureau of Investigation (FBI) and comprised the database. Data analyzed included homicide type, situation, circumstance, firearm type and demographics of victims and offenders. Incidence of firearm homicide was stratified by year and compared over time using simple linear regression.

Results: 485,288 incidents of firearm homicide were analyzed (64% of 752,935 total homicides). Most victims were male (85%), black (53%) and had a mean age of 33; offenders were predominantly male (67%), black (39%) with a mean age of 30. 54% of all homicides involved a single victim and single offender, followed by a single victim and unknown offender(s) (31%); 4.4% of firearm homicides had multiple victims. Overall, handguns, shotguns and rifles accounted for 76%, 7% and 5% of all firearm homicides, respectively; 11% had no firearm type listed and < 1% were unknown. Linear regression analysis identified a significant increase in the incidence of firearm homicides from 61% in 1980 to 71% in 2016 ($\beta = 0.25$, p<0.0001).

Conclusions: Gun violence represents an ongoing public health concern with the incidence of firearm homicides steadily and significantly increasing over the past 37 years. FBI homicide data can serve to supplement trauma registry data by helping to
define gun violence patterns. However, stronger partnerships between local law enforcement agencies and trauma centers are necessary to (1) better characterize firearm type and resultant injury patterns, (2) direct prevention efforts and firearm policy and (3) reduce gun-related deaths.

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13. A WOLF IN SHEEP’S CLOTHING: PAPILLARY THYROID MICROCARCINOMA IN THE UNITED STATES OF AMERICA

Ziad Al-Qurasyshi*    Ralph P. Tufano*
R. Michael Tuttle*    Emad Kandil

Introduction: Papillary thyroid microcarcinoma (PTMC) is viewed as a relatively non-aggressive malignancy. The overdiagnosis and overtreatment of PTMC has led to an emerging trend of less extensive surgery and an inclination toward active surveillance of those tumors. In this study we aim to examine the risk of aggressive PTMC in the United States.

Methods: Retrospective analysis utilizing the National Cancer Database, 2010 – 2014.

Results: A total of 19,876 adult patients with PTMC were identified. The mean age of the study sample was 48.9 ± 13.6 years. The median follow-up time was 39 months (interquartile range:25.7 – 54.3 months). 4,916 (24.7%) patients presented with aggressive features, including central neck nodal metastasis (11.9%), lateral neck nodal metastasis (6.5%), extrathyroidal extension (ETE) (8.5%), lymphovascular invasion (LVI) (5.3%) & distant metastasis (0.5%). Presence of distant metastasis was the only finding associated with a lower survival [HR: 3.18, 95%CI: (1.31, 7.75), \(p=0.012\)]. However, distant metastasis was predicted by central [OR: 2.08, 95%CI: (1.24, 3.49), \(p=0.006\)] and lateral [OR:2.89, 95%CI: (1.60, 5.23), \(p=0.001\)] compartment lymph node metastasis, and nodal metastasis was predicted by ETE [OR: 3.85, 95%CI: (3.45, 4.29), \(p<0.001\)] and LVI [OR: 7.38, 95%CI: (6.44, 8.45), \(p<0.001\)]. Additionally, ETE and LVI were significantly associated with each other \((p<0.001)\). Patients with ETE benefited the most from radioactive iodine therapy (RAI) following surgical resection [HR: 0.31, 95%CI: (0.12, 0.83), \(p=0.020\)].

Conclusions: In United States, PTMC could exhibit aggressive features in 25% of the patients upon presentation and the presence of DM, albeit rare affects overall survival. Clinicians need to be cognizant of this considerable risk in the era of less aggressive management of PTMC. Careful screening of patients with PTMC for the presence of any of those aggressive features should be performed before a management plan is established.

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14. ADMISSION PHYSIOLOGY, NOT BLOOD PRESSURE, PREDICTS THE NEED FOR OPERATING ROOM THORACOTOMY AFTER PENETRATING THORACIC TRAUMA

James V. O’Connor*    Molly Deane*
Benjamin Moran*     David V. Feliciano
Samuel M. Galvagno, Jr*   Thomas M. Scalea

Introduction: Approximately 15% of patients with penetrating thoracic trauma require an emergency center or operating room thoracotomy, usually for hemodynamic instability or persistent hemorrhage. The hypothesis in this study is that admission physiology, not vital signs, predicts the need for operating room thoracotomy.

Methods: Trauma registry review, 2002-2017, of adult patients undergoing operating room thoracotomy within 6 hours of admission (emergency department thoracotomies excluded). Demographics, injuries, admission physiology, time to operating room (OR), operations, and outcomes were reviewed. Data are reported as mean (standard deviation) or median (interquartile range).

Results: Of the 301 consecutive patients in this 15-year review, 75.6% were male at a mean age 31.1 years (11.5) and 41.5% had gunshot wounds. The median Injury Severity Score was 25 (16-29), time to OR 38 minutes (19-105), and 21.9% had a thoracic damage control operation; of interest, 29.2% had an associated damage control laparotomy. Mean admission systolic blood pressure was 115 mm Hg (37), with only 24% <90 mm Hg; however, admission pH 7.22 (0.14), base deficit 7.6 (6.1), and lactate 7.2 (4.5) were markedly abnormal. All patients with isolated aerodigestive injuries were stable on admission. Overall, there were 136 (45.2%) patients with significant pulmonary injuries treated with 112 major non-anatomic resections, 17 lobectomies, and 7 pneumonectomies; respective mortalities were 2.7%, 11.8%, and 42.9%. There were 100 (33.2%), cardiac, 30 (9.9%) great vessel, 14 (4.7%) aerodigestive, and 58 (19%) combined thoracic injuries. Mortality for cardiac, great vessel, and aerodigestive injuries was 7%, 0%, and 9.1%, respectively. Overall mortality was 6.6%, 15.2% after damage control and 3.8% for all others.
Conclusions: Shock characterized by acidosis, but not hypotension, is the most common presentation in patients who will need operating room thoracotomy after penetrating thoracic trauma. Survival rates are excellent unless a pneumonectomy or damage control thoracotomy is required.

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15. REGIONAL VARIATION IN THE APPROPRIATENESS OF NON-HCC MELD EXCEPTIONS

Robert M. Cannon*    Malay B. Shah*
Eric G. Davis*    Jayme E. Locke
David S. Goldberg*    Kelly M. McMasters
Raymond J. Lynch*    Christopher M. Jones

Background: Patients thought to be at greater risk of liver waitlist dropout than their laboratory MELD (lMELD) score reflects are commonly given MELD exceptions, where a higher allocation MELD (aMELD) score is assigned that is thought to reflect the patient’s risk. This study was undertaken to determine whether exceptions for reasons other than hepatocellular carcinoma (HCC) are justified, and whether exception aMELD scores appropriately estimate risk.

Methods: Adult primary liver transplant candidates listed at a single center in the current era of liver allocation in the UNOS database were analyzed. Patients granted non-HCC related MELD exceptions and those without MELD exceptions were compared. The outcomes of waitlist dropout and liver transplantation were analyzed using cause-specific hazards regression, with separate models fitted to adjust for lMELD and aMELD.

Results: There were 29,243 patients, with 2,555 in the exception group. Nationally, exception patients were more likely to dropout (HR: 1.391.551.73; p<0.001) or undergo liver transplant (HR: 3.253.443.63; p<0.001) than their lMELD adjusted counterparts. Adjusting for aMELD, exception patients were more likely to dropout (HR: 1.321.481.65; p<0.001) and less likely to undergo liver transplant (HR: 0.790.840.89; p<0.001). There was significant regional variation in both the appropriateness of MELD exception status and the effectiveness of risk estimation (Figure).

Conclusions: Despite appropriate utilization of non-HCC MELD exceptions on a national level, individual UNOS regions such as those covering New York and New England appear to overutilize these exceptions, giving an unjustified advantage to exception patients. This supports the need for national standardization of MELD exceptions. Adjusted cause specific hazard ratios for liver transplant and waitlist dropout associated with non-HCC MELD exception status, stratified by region. Error bars represent 95% confidence intervals. Confidence intervals that do not cross 1 indicate statistical significance a: Hazard ratios for waitlist dropout, adjusted for
laboratory MELD. b: Hazard ratios for liver transplant, adjusted for laboratory MELD.

c: Hazard ratios for waitlist dropout, adjusted for allocation MELD. d: Hazard ratios for liver transplant, adjusted for allocation MELD.

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16. UTILIZATION OF COMPLETION LYMPH NODE DISSECTION FOR SENTINEL LYMPH NODE POSITIVE MELANOMA HAS DECREASED OVER TIME

Joshua Herb*             Lisette Dunham*
Karyn B. Stitzenberg*    Michael O. Meyers

Introduction: For patients with sentinel node positive melanoma (SNPM), randomized trials, first reported in early 2016, questions the utility of routine completion lymph node dissection (CLND) for selected patients. This study examines time trends in CLND and explores institutional and clinical factors associated with CLND.

Methods: The National Cancer Database was queried for patients > 18 years old from 2012-2016 with SNPM. A high-volume center was defined as > 80th percentile for number of sentinel node procedures. Poisson regression assessed temporal trends, and identified patient, pathologic, and institutional characteristics associated with CLND.

Results: From 2012-2016, 7,146 patients with SNPM were identified. The proportion of patients undergoing CLND was steady in years 2012-2014, but decreased to 57% in 2015 and 50% in 2016 (p<0.0001, Table). The proportion of CLNDs decreased over time for both high volume (66% to 52%, p<0.0001) and lower volume centers (55% to 45%, p<0.06). Female sex (RR 0.92, p<0.001) and increasing age (RR 0.98, p<0.0001) were associated with lower likelihood of CLND. Increased Breslow depth (RR 1.016, p<0.01), ulceration (RR 1.054, p<0.05), and high-volume centers (RR 1.176, p<0.0001) were associated with higher likelihood of CLND. Regional differences in likelihood of CLND were also present (p<0.0001).

Conclusions: CLND in SNPM decreased over time, with the greatest change in 2016. Several patient, pathologic, and institutional characteristics were associated with likelihood of CLND. As evidence supports close observation for selected patients, efforts should be undertaken to improve and standardize patient selection for CLND across institutions caring for patients with melanoma.

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<td>1449</td>
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<td><strong>Proportion with CLND</strong></td>
<td>63%</td>
<td>61%</td>
<td>62%</td>
<td>57%</td>
<td>50%</td>
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17. GERIATRIC-SPECIFIC VARIABLES CONTRIBUTE TO 30-DAY HOSPITAL READMISSION RISK OF ELDERLY PATIENTS POSTOPERATIVELY

Allison Martin*     Victor Zaydfudium*
Florence E. Turrentine*    R. Scott Jones

Introduction: Patients 80 years of age and older undergo an increasing number of surgical operations performed annually in the United States. The elderly present with unique health-care challenges including their frailty. Preventing postoperative readmission remains an important challenge to improving surgical care. This study examined whether geriatric specific variables, some representing frailty, contributed to postoperative readmissions of elderly patients.

Methods: We joined the ACS Geriatric Surgery Research File (GSRF) with the ACSNSQIP PUF files for 2014-2015. This data set included 15 GSRF variables and 35 ACSNSQIP variables. We used a multivariable logistic regression model with readmission as the dependent variable.

Results: The data represented 6,040 patients: 3618 (60.5%) 65-74 yr., 1861 (31.2%) 75-84 yr., and 496 (8.3%) ≥85 yr. Females comprised 54.5% of the patients. 200 patients (3.3%) died within 30 days and 1461 (24.2%) patients had a postop complication. 659 patients (10.9%) had unplanned readmissions. 1169 (19.4%) patients had pancreatic or hepatobiliary operations, 3521 (58.3%) had colorectal operations, 908 (15.0%) had hernia operations, 240 (4.0%) had thyroid or esophageal operations, and 201 (3.3%) had appendix operations. 744 (12.3%) patients had emergency operations. Morbidity and Return to OR (ACSNSQIP variables) strongly predicted readmission followed by Incompetent on Admission and Fall Risk at Discharge (GSRF variables). Use of Mobility Aid and Discharged to SNF (GSRF variables) increased the risk of readmission by 26% and 22% respectively. Work RVU (ACSNSQIP), Discharge Destination (GSRF), and New DNR Classification (GSRF) had no influence on readmission. The Hosmer-Lemeshow P value of 0.08 and a C statistic of 0.75 endorse the data fit in this model.

Conclusions: Four GSRF variables were important in the evaluation of postoperative readmission of elderly patients. Three ACSNSQIP variables were important in the evaluation of postoperative readmission of elderly patients. The strongest predictors of readmission of elderly patients were Morbidity and Return to OR.
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<td>Return to OR</td>
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<td>2.07-3.79</td>
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<td>Incompetent on admission</td>
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</table>

Table 1. Odds ratios of significant variables
18. NIPPLE-SPARING MASTECTOMY IS AN ONCOLOGICALLY SAFE OPTION FOR APPROPRIATELY SELECTED PATIENTS

Julie A. Margenthaler    Amy E. Cyr*
Connie Gan*          Marissa Tenenbaum*
Yan Yan*               Terence M. Myckatyn*
Diana Hook*

Introduction: Nipple sparing mastectomy (NSM) is an alternative to skin sparing mastectomy in appropriately selected patients. The aim of this study was to review our experience with NSM and to evaluate for oncologic safety.

Methods: Patients who underwent NSM at our institution from September 2008 to August 2017 were identified after IRB approval. Data included patient age, tobacco use, tumor size, hormone receptor status, lymph node status, radiation and chemotherapy use, incision type, and reconstruction type. Statistical analyses were performed using ANOVA and chi-squared tests.

Results: 322 patients underwent 588 NSM (83% bilateral, 17% unilateral), including 399 (68%) for malignancy [Stage 0 (27%), I (44%), II (25%) and III (4%)]. The overall rate of wound complications was 19%. Tobacco use increased complications (37.5%|16.3%, p<0.001), as did adjuvant radiation therapy (31.4%|17.4%, p=0.014). Patients with lymph node involvement and larger tumor size had higher rates of complications (31.3%|17.2%, p=0.016; p=0.033). Patients undergoing circumareolar incisions had a higher rate of complications than those undergoing lateral, inframammary fold, or curvilinear incisions (43.5%|17.4%|17.4%|14.3%, p=0.018). Six (1%) local chest wall recurrences occurred during the follow-up period, none of which involved the nipple areolar complex. Four patients (1%) suffered a distant recurrence.

Conclusions: Most NSM performed at our institution are in patients with malignancy. The oncologic safety is confirmed by the low locoregional recurrence rate. Tobacco use and adjuvant radiation therapy remain the most significant risk factors for complications, highlighting the need for careful patient selection and patient counseling regarding modifiable risk factors and expected outcomes.

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19. LONG-TERM CUMULATIVE ADHESIVE SMALL BOWEL OBSTRUCTION EPISODES AND THE RISK OF RECURRENCE

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Li Wang* Oscar D. Guillamondegui
Chris Lindsell*

Background: Recurrence of adhesive small bowel obstruction (ASBO) can lead to multiple admissions. There is limited knowledge of the role of operative and non-operative treatment in the long-term recurrence risk for ASBO. We sought to determine the effect of operative and non-operative management on future ASBO recurrences.

Methods: This is a retrospective study of administrative discharge data from the Tennessee Hospital Association. Adult discharges from 2007 to 2009 with ASBO and all subsequent readmissions within any hospital in the state were included; patients with prior ASBO from 2003 to 2007 and out-of-state residents were excluded. Operative and non-operative managements were compared. The primary outcome was ASBO recurrence using the Andersen-Gill approach for modeling recurrent time-to-event data; secondary outcomes included mortality and time-to-recurrence.

Results: 6,191 records were analyzed, 30.0% were initially treated operatively. Patients initially managed surgically had lower overall recurrence (19.0% vs. 25.6%, p<0.005). The hazard for recurrence was lower if the most recent ASBO management was operative (HR 0.27, 95% CI, 0.23-0.31). The risk of ASBO recurrence increased with more cumulative operative or non-operative ASBO admissions relative to patients with fewer prior admissions (operative: HR 2.30, 95% CI, 2.04-2.60; non-operative: HR 1.18, 95% CI, 1.16-1.20). In-hospital mortality (3.7% vs. 2.6%, p=0.025) and time-to-recurrence (729 vs. 550 days, p=0.009) were greater in the operative group.

Conclusions: Operative management for the most recent ASBO is associated with fewer recurrences. Subsequent cumulative recurrences of ASBO predispose to recurrence regardless of operative or non-operative management. When considering ASBO management ASBO, subsequent recurrences should be considered.

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Introduction: Recent studies have demonstrated that a majority of surgeons suffer significant pain and musculoskeletal discomfort (MSD) after operating. This may reduce career longevity. Poor ergonomics contribute to this phenomenon.

Methods: Wearable inertial measurement units (IMUs) measured deviations from neutral posture positions at the cervical spine, back, and upper extremities via the fusion of data from an accelerometer, magnetometer, and gyroscope in real time. Ergonomic risk was calculated based on the procedure time in defined, high risk positions and compared cross procedure categories (open, laparoscopic, endovascular), equipment (loupes, headlights, lead), and case complexity.

Results: 53 surgeons representing 12 surgical specialties were evaluated during 115 cases. Overall, surgeons spent 65% of procedure time in high or critical risk neck positions. High risk posture for the torso and extremities was observed 30% and 13% of operative time, respectively. The highest neck risk was during open procedures (adjusted odds ratio 31.1, CI 8.47-114.41; p<0.001). The use of surgical loupes and headlamps were independently associated with increased time in ergonomically unfavorable neck positions (P<0.0001 and P=0.0071, respectively).

Conclusions: Surgeons face significant physical stress due to ergonomic issues. Specifically, surgeons’ cervical spines and back are in high risk positions for a majority of operative time. The risks to neck, back, and extremities vary by specialty and procedure. Poor ergonomics may cause chronic pain and disability, reducing career longevity and threatening the public’s access to surgical care.

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21. CARDIAC DYSFUNCTION AFTER BURN INJURY INVOLVES THE PDE5-cGMP-PKG-Sirt1-PGC1α

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Introduction: Mitochondrial oxidative stress plays a prominent role in the development of burn-induced cardiac dysfunction. Two key mitochondrial oxidative stress pathways are the phosphodiesterase 5 (PDE5)-cyclic GMP (cGMP)- protein kinase G (PKG) pathway and the AMP-activated protein kinase (AMP)- sirtuin 1 (Sirt1)- peroxisome proliferator activated receptor γ coactivator 1α (PGC1α) pathway.

Methods: Male Sprague Dawley rats underwent sham procedure or 60% total body surface area full-thickness burn. Echocardiograms were performed 24 hours post burn (hpb). Tissues were harvested 24 hpb and analyzed using Nano LC MS/MS, ELISA, Masson T staining, qPCR, and Western blotting.

Results: After burn, PDE5 protein levels increased 91-fold (p<0.001) and mRNA levels increased 2.3-fold; cGMP protein levels decreased 64% (p<0.001); PKG protein levels decreased 3-fold (p<0.001) and mRNA levels decreased 32%. Recovery in the PDE5-cGMP-PKG pathway was noted with sildenafil treatment. Sildenafil similarly resulted in recovery of burn-induced cardiac physiological dysfunction, with normalization of burn-induced depression of cardiac output (p<0.01), stroke volume (p<0.01), and ejection fraction (p<0.01). Collagen expression increased 6.8-fold (p<0.001) following burn and normalized with sildenafil treatment. Similarly, significant increases in Masson’s T score (p<0.05), ANP (p<0.001), BNP (p<0.001), αSMA (p<0.001) and actin (p<0.001) were also normalized with sildenafil. Following burn, AMPK mRNA expression decreased 60% (p<0.001), Sirt1 protein level decreased 4.5- fold, and PGC-1α mRNA levels decreased 79% (p<0.001).

Conclusions: The mitochondrial oxidative stress pathways PDE5-cGMP-PGC and AMPK-Sirt1-PGC1α play an important role in the pathogenesis of burn-induced cardiac dysfunction. Targeted therapeutics, such as sildenafil, may improve cardiac function after severe burn.

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22. COGNITIVE IMPAIRMENT IS ASSOCIATED WITH LOSS OF INDEPENDENCE IN OLDER PATIENTS FOLLOWING SURGERY FOR COLORECTAL CANCER

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Eric Do* Thomas H. Magnuson
Oluwafemi Owodunni*

Introduction: Frailty is associated with adverse clinical outcomes including mortality following surgery for colorectal cancer in patients ≥ 65 years. However, studies evaluating the effect of frailty on functional outcomes are lacking. The aim of this study was to determine the impact of frailty on loss of independence (LOI) among colorectal cancer patients entered into the Geriatric Pilot in NSQIP.

Methods: This prospective study included data from patients who underwent surgery for colorectal cancer from 2014-2016 and were included in the geriatric pilot within the NSQIP participant use file. Frailty was assessed using the modified frailty index and a score ≥ 2 was considered frail. Functional status was defined by assistance with activity of daily life. Major complications were assessed using the Claven-dindo (CD) scoring system. Multivariable analyses examining 30-day postoperative outcomes including length of stay (LOS), CD, readmissions, and LOI were performed.

Results: 533 patients met inclusion criteria; overall characteristics are shown in table 1. Frail patients had a higher BMI (31 vs. 27, p<0.001), were more dependent (11.4% vs. 1.5%, p<0.001), and lacked advanced care plan (15.4% vs. 23.9%, p=0.05) when compared to non-frail patients. Overall, frailty was associated with an increased risk of a higher CD (OR 1.6, 95% CI:1.3-1.9, p<0.001) and readmission (OR 1.5, 95% CI:1.3-1.8, p<0.001), but not LOI. Patients at increased risk for LOI were female (OR 1.5, 95% CI:1.0-2.1, p<0.001), cognitively impaired (OR 3.1, 95% CI:2.9-3.4, p<0.001), and required a new mobility aid (OR 3.7, 95% CI:3.3-4.2, p<0.001).
Conclusions: 1 out of 5 older patients undergoing surgery for colorectal cancer, regardless of frailty status, experience LOI and cognitive impairment was associated with a higher risk. Our findings indicate that future studies should evaluate long-term risks for LOI and explore interventions to optimize this patient population.

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23. CHOICE ARCHITECTURE, THRESHOLD EFFECTS AND RELATIVE SOCIAL RANKING- USING BEHAVIOURAL ECONOMIC PRINCIPLES TO PROMOTE BETTER SURGEON ACCOUNTABILITY FOR OPERATING ROOM COSTS

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Anaeze Offodile* A. Park*
A.P. Sen* J. Terrell*
S. Holtsmith* R.L. Bassett*
F. Haider*

Background: Operating room (OR) costs account for a significant portion of inpatient spending but most surgeons are unaware of procedural costs. We leveraged behavioral economics principles and a cost transparency tool to impact discretionary OR spending (disposable supplies).

Methods: A single institution, prospective study, conducted from January 1st to December 31st, 2018 across 3 departments: Urology, Thoracic and Endocrine. 2016 and 2017 represented our “pre-baseline” and “baseline” years respectively. 2 self-selected procedures per department were subjected to intraoperative supply costs (ISC) feedback via a custom dashboard and monthly email reports. Behavioral economics principles like relative peer ranking and threshold effects were used in the study design. Primary outcome was the percentage change in the department-level mean supply costs per case determined via an interrupted time series mixed effects model.

Results: A total of 2,857 procedures and 26 surgeons comprised our analytical sample. Costs decreased in 5 of the 6 procedures in 2018. On average, there was a significant monthly decrease in costs of approximately 0.5% over the study period (p =0.0004). Post-intervention, there was a non-significant additional decrease of 0.6% in monthly costs (p = 0.0648). However, there was a highly significant 20% drop in overall costs due to the intervention (p < 0.0001). Similar results were noted on sensitivity analysis. There were no significant changes in incidence of post-operative complications due to our intervention.

Conclusions: Deployment of a cost feedback tool using behavioral economics principles resulted in a significant decrease in OR spending without negatively impacting complication rates.

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24. STANDARD PREPARATION METHODS LEAD TO PREVIOUSLY UNRECOGNIZED AND POTENTIALLY DAMAGING CELLULAR CONTAMINATION OF PLASMA PRODUCTS

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Matthew E. Kutcher*    Danielle M. Tatum*
Kristen T. Carter*    Juan C. Duchesne*
Yong B. Tan*          Alison A. Smith*
Gina C. Capley*       Jon D. Simmons

Background: Liquid and fresh frozen plasma (FFP) are widely considered functionally acellular; however, recent reports suggest that these products contain large amounts of cellular debris. The freeze-thaw process required for FFP extraction induces membrane rupture, potentially masking cellular contamination and facilitating delivery of deleterious Damage-Associated Molecular Patterns (DAMPs) during transfusion. While leukoreduction of transfusion-ready platelets and red cells is mandated, current plasma preparation methods do not include this standard. To test the hypothesis that plasma products contain significant cellular contamination, we quantified leukocyte and platelet levels in units of never-frozen liquid plasma.

Methods: Samples from never-frozen liquid plasma (n=25) were obtained from the regional blood centers supplying three major trauma centers located in the southeastern United States. Samples were analyzed for leukocyte and platelet contamination by flow cytometry (Sysmex XN). To determine if leukoreduction of whole blood prior to centrifugation prevents cellular contamination of liquid plasma, Site B created six additional units of liquid plasma from leukoreduced whole blood which were compared to units of liquid plasma derived by standard processing.

Results: Across all centers, each unit of non-leukoreduced (non-LR) never-frozen liquid plasma contained a mean of 12.8 ± 3 million leukocytes (Figure - Site A: n=6, 7.0 ± 1.8 million; Site B: n=6, 12.3 ± 2.9 million; Site C: n=13, 15.7 ± 5.5 million), and 4.6 ± 2 billion platelets (Site A: n=6, 0.35 ± 0.05 billion; Site B: n=6, 4.2 ± 0.3 billion; Site C: n=13, 6.7 ± 3.8 billion). Introduction of a whole blood filter leukoreduction (LR) step prior to plasma extraction essentially eliminated all leukocyte (Figure - Site C Non-LR: 12.3 ± 2.9 million vs Site C LR: 0.05 ± 0.05 million leukocytes) and platelet (Non-LR: 4.2 ± 0.3 billion platelets vs LR: 0.00 ± 0.00 billion platelets) contamination.
Conclusions: Despite widespread belief that liquid plasma and FFP are functionally acellular, liquid plasma at three regional blood banks reveal previously unrecognized significant leukocyte contamination. This potentially avoidable source of inflammatory DAMPs may be a significant driver of transfusion-related side effects and end-organ injury. Introduction of a leukoreduction step prior to whole blood centrifugation essentially eliminated detectable leukocyte contaminants from plasma, highlighting a straightforward method to mitigate cellular contamination without additional cost.

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Figure: Independent Association of Perioperative Drain Placement with Postoperative Outcomes Based on Modified Fistula Risk Score
ASSESSING THE UTILITY OF POST-MASTECTOMY IMAGING FOLLOWING BREAST RECONSTRUCTION

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Gloria Broadwater*    Tori Wickenheisser*
Roger W. Cason*    Jonah Orr*
Adam D. Glener*    Caitlin Marks*
Amanda R. Sergesketter*    Scott T. Hollenbeck
Rebecca Vernon*

Introduction: Few guidelines exist regarding surveillance and diagnostic breast imaging after mastectomy and breast reconstruction. This study investigates the influence of breast reconstruction on the frequency of post-mastectomy imaging, the utility of imaging, and its effect on overall and locoregional recurrence-free survival.

Methods: A retrospective review identified breast cancer patients (n=1216) who underwent mastectomy with or without reconstruction. Logistic regression identified predictors of post-reconstruction imaging. Kaplan-Meier methods determined the impact of post-reconstruction imaging on overall and locoregional recurrence-free survival.

Results: 662 (54.4%) patients underwent mastectomy only and 554 (45.6%) underwent breast reconstruction. Breast reconstruction patients were more likely to receive post-mastectomy imaging compared to mastectomy only patients (n=205, 37.0% vs. n=168, 25.4%; p<.0001); however, this difference was not statistically significant after adjusting for covariates (p=0.16). Most radiographic studies were BI-RADS 1 (n=58, 30%) or 2 (n=95, 49%) and were ordered by non-surgical providers (n=128, 63%). Post-reconstruction breast imaging did not influence overall or locoregional recurrence-free survival (Figure). The 5-year survival probability for breast reconstruction patients who underwent breast imaging for a palpable mass, surveillance, or who did not undergo imaging was 100%, 95% (95% CI:89-100%), and 96% (95% CI: 94-99%), respectively. Post-reconstruction imaging was not a significant predictor of overall survival (HR, 0.95; 95% CI 0.61-1.46; p=0.30).

Conclusions: The limited utility of routine post-reconstruction breast imaging should be reinforced when evaluating breast reconstruction patients. Multidisciplinary collaboration should be emphasized when attempting to distinguish benign post
surgical findings from a malignant process to reduce unnecessary imaging and biopsies following breast reconstruction.

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Figure: Kaplan-Meier Probability for overall survival (left) and locoregional recurrence-free survival (right).
Background: Approximately 20% of patients with colorectal cancer (CRC) present with synchronous liver metastases (CRLM). The decision to resect simultaneously or sequentially remains controversial. The primary aim of this study was to determine whether simultaneous resection of CRC and CRLM is associated with increased complications compared to isolated resection.

Methods: Prospective data from ACS-NSQIP including the ACS-NSQIP procedure-specific colectomy and hepatectomy modules from 2014-2016 were reviewed in a retrospective cohort study. Primary study outcome was combined 30-day complication rates; secondary outcomes included colectomy and hepatectomy-specific complications. Multivariable (MVA) logistic regression was performed to control for confounding factors associated with postoperative complications.

Results: A total of 23,643 patients underwent colectomy, 7,462 hepatectomy, and 592 simultaneous resections for CRC and CLRM. Overall morbidity was higher among patients treated with simultaneous resection (26.9%) compared to either isolated colorectal (18.2%) or hepatic resection (15.1%; p<0.001). Additionally, postoperative ileus (36.4% vs. 19.1%) and anastomotic failure (7.9% vs. 3.8%) were more common after simultaneous resection compared to colorectal resection (p<0.05). Similarly, rates of bile leak (8.5% vs. 6.6%, p=0.30) and post-hepatectomy liver failure (8.5% vs. 4.1%, p<0.01) were higher after simultaneous resection compared to isolated hepatectomy. By MVA, simultaneous resection was associated with increased overall complications compared to isolated colon [OR 1.83 (95% CI 1.51-2.20)] or liver resections [OR 2.06 (95% CI 1.70-2.51)], as well as increased procedure-specific complications (Figure).

Conclusions: Although simultaneous resection offers definitive resection for patients with synchronous CRC and CRLM, it is associated with significantly increased 30-day overall and procedure-specific postoperative morbidity.
### Odds Ratio and 95% Confidence Interval

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Module</th>
<th>Versus isolated colorectal</th>
<th>Versus isolated hepatic</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any major morbidity</td>
<td>Core dataset</td>
<td>1.83</td>
<td>1.51</td>
<td>2.20</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.06</td>
<td>1.70</td>
<td>2.51</td>
</tr>
<tr>
<td>Any major morbidity</td>
<td>Colectomy module</td>
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<td>1.46</td>
<td>2.49</td>
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<td>Versus isolated colorectal</td>
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<td>1.26</td>
<td>2.52</td>
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<tr>
<td>Bile leak and/or anastomotic leak</td>
<td>Versus isolated colorectal</td>
<td>1.83</td>
<td>1.23</td>
<td>2.61</td>
<td></td>
</tr>
<tr>
<td>Any major morbidity</td>
<td>Hepatectomy module</td>
<td>1.56</td>
<td>1.09</td>
<td>2.22</td>
<td></td>
</tr>
<tr>
<td>Any major morbidity + bile leak and/or liver failure</td>
<td>Versus isolated hepatic</td>
<td>1.40</td>
<td>1.00</td>
<td>1.96</td>
<td></td>
</tr>
<tr>
<td>Bile leak and/or liver failure</td>
<td>Versus isolated hepatic</td>
<td>1.18</td>
<td>0.76</td>
<td>1.81</td>
<td></td>
</tr>
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</table>

1 Adjusted for age, sex, race, body mass index, ASA classification, and comorbidities.
Background: It has been reported that approximately 65% percent of patients experience moderate to severe postoperative pain, which delays recovery and increases risk of developing chronic pain. Opioids have historically been considered the mainstay of therapy for the treatment of refractory moderate to severe acute postoperative pain. However, opioid related adverse drug events are associated with worse clinical outcomes and increased costs of care. Furthermore, 1 in 16 surgical patients prescribed opioids becomes a long-term opioid user. The Centers for Disease Control reported in 2017 that the largest increments in probability of continued use were observed after the fifth and thirty-first days on opioid therapy. This study demonstrates the correlation between a multi-pronged system-wide pain management and opioid stewardship effort with reduction in discharge prescriptions, prescriptions written for greater than five days, and opioid consumption for all surgical patients.

Methods: Discharge prescriptions were monitored through the healthcare system’s electronic health record. Baseline prescribing patterns were established for the first quarter of 2018, preceding the first intervention in the multipronged opioid reduction initiative. Beginning in the second quarter of 2018, a series of pain management and opioid stewardship educational conferences were incorporated into surgical grand rounds lecture series throughout the system. Enhanced recovery after surgery (ERAS) protocols were simultaneously implemented systemwide, promoting treatment with non-opioids, regional analgesia, and using opioids as a last resort for breakthrough moderate to severe pain. In the third quarter of 2018, system leadership adopted a quality metric linked to compensation, rewarding surgeons for limiting post-operative discharge prescriptions to five or fewer days. Opioid prescriptions were compared by quarter from January 2018 to March 2019 using chi square and Kruskal-Wallis test with significance of p<0.05.
**Results:** 31,814 patients underwent elective surgery during the study period. A breakdown of prescribing patterns by quarter are demonstrated below:

<table>
<thead>
<tr>
<th>Quarter</th>
<th># patients</th>
<th># ≤5 days (%)</th>
<th># &gt;5 days</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2018</td>
<td>6361</td>
<td>5133 (81)</td>
<td>1228</td>
<td></td>
</tr>
<tr>
<td>Q2 2018</td>
<td>6577</td>
<td>5377 (82)</td>
<td>1200</td>
<td>0.1257</td>
</tr>
<tr>
<td>Q3 2018</td>
<td>6522</td>
<td>5586 (86)</td>
<td>936</td>
<td>0.0001</td>
</tr>
<tr>
<td>Q4 2018</td>
<td>5999</td>
<td>5366 (89)</td>
<td>633</td>
<td>0.0001</td>
</tr>
<tr>
<td>Q1 2019</td>
<td>6355</td>
<td>5923 (92)</td>
<td>432</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

Average total morphine equivalent daily dose declined during the five quarters from 38.5 mg in the first quarter to 34.0 mg in the fifth quarter.

**Conclusions:** A system wide, multi-pronged pain management and opioid reduction program significantly reduced opioid discharge prescriptions written for greater than five days. Individual service lines have the opportunity for further improvement. This approach can serve as a model for other hospitals and health care systems attempting to reduce opioid prescribing and combat the opioid crisis in the United States.

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Introduction: Compared to the Model for Endstage Liver Disease (MELD) the Albumin-Bilirubin (ALBI) score is a better predictor of post-hepatectomy liver failure and bile leaks. However, the relative value of ALBI and MELD in predicting post-hepatectomy mortality has not been adequately evaluated. Therefore, the aim of this study was to compare ALBI and MELD in predicting post-hepatectomy mortality.

Methods: Patients undergoing major hepatectomy (≥ 3 segments) or partial hepatectomy (≤ 2 segments) were identified in the 2014-2017 ACS-NSQIP procedure targeted Participant Use File. Patients with missing laboratory data were excluded. Univariate and multivariable analyses were performed for postoperative mortality. Receiver Operator Curves (ROC) were performed, and an Area Under the Curve (AUC) was generated as a validation for ALBI and MELD.

Results: Of 13,783 patients, univariate analysis demonstrated that increasing ALBI Grade was significantly associated with mortality (ALBI Grade 2 OR 3.33, p < 0.001; ALBI Grade 3 OR 13.34, p < 0.001), as was MELD ≥ 10 (OR 2.25, p < 0.001). However, multivariable analysis revealed ALBI Grade 2/3 to be a better predictor of mortality (OR 3.35, p < 0.001) versus MELD (OR 1.73, p < 0.001). In addition, for all patients, ALBI score had better discrimination when compared to MELD for mortality (AUC 0.71 vs.0.68) and especially for patients with hepatocellular carcinoma (AUC 0.70 vs. 0.58) (Figure).

Conclusions: Increasing Albumin-Bilirubin (ALBI) grade is a powerful predictor of post-hepatectomy mortality. Compared to MELD, ALBI score is more accurate in predicting mortality following hepatectomy, especially in patients with hepatocellular carcinoma.

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Figure. Area under the receiver operative curves (ROC) for mortality comparing ALBI and MELD for all patients (A and B) and patients with hepatocellular carcinoma (HCC) (C and D).

<table>
<thead>
<tr>
<th></th>
<th>All Patients</th>
<th>All Patients</th>
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</thead>
<tbody>
<tr>
<td>AUC</td>
<td>0.71</td>
<td>0.68</td>
</tr>
<tr>
<td>95% CI</td>
<td>0.67-0.75</td>
<td>0.64-0.72</td>
</tr>
<tr>
<td>P-value</td>
<td>&lt;0.001</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>HCC Patients</th>
<th>HCC Patients</th>
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</thead>
<tbody>
<tr>
<td>AUC</td>
<td>0.70</td>
<td>0.58</td>
</tr>
<tr>
<td>95% CI</td>
<td>0.63-0.77</td>
<td>0.50-0.66</td>
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<tr>
<td>P-value</td>
<td>&lt;0.001</td>
<td>0.059</td>
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</table>
29. **COLON CANCER IN PATIENTS UNDER 25 YEARS OLD: A DIFFERENT DISEASE THAN IN ADULTS?**

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Songphol Malakord*  
Lian Chun*  
Miguel Rodriguez-Bigas*  
Andrea Hayes-Jordan

**Introduction:** The aim of this study was to compare the stage-for-stage overall (OS) and recurrence free (RFS) survival between adult and pediatric/adolescent colon cancer patients.

**Methods:** A retrospective review of non-syndromic pediatric/adolescent patients < 25 years old treated between 1991 and 2017 at UT MD Anderson Cancer Center, was compared with a prospectively maintained database of adult patients. Outcome variables were compared and OS and RFS were estimated using the Kaplan-Meier method and the log rank test and multivariable Cox models.

**Results:** The cohort was 94 pediatric patients and 765 adult patients. Overall, the 3-year OS rate for adult and pediatric patients respectively was 90% and 41.92% (95% CI:87%-92%) (p< 0.0001), and the 3-year RFS rate was 78% and 32% (p< 0.0001). The stage-for-stage 5-year OS rates for adult vs. pediatric patients were: Stage 1–96% vs 100% (p=0.793); Stage 2–90% vs 64% (p<0.0001); Stage 3–85% vs. 58% (p<0.0001); Stage 4–55% vs. 16% (p<0.0001). The stage-for-stage 5-year RFS rates for adults vs. children were: Stage 1–95% vs. 100%; Stage 2– 85% vs. 55% (p=0.0002); Stage 3–73% vs 31% (p<0.0001); Stage 4–27% vs 5% (p<0.0001). Pediatric/adolescent patients had a higher risk of recurrence or death than adult patients on multivariate analysis (HR=2.312, 95% CI:1.615–3.313 (p<0.0001). Histologic grade & type, microsatellite instability and primary site were significant on univariate analysis.

**Conclusions:** Stage-for-stage, pediatric/adolescent patients had shorter 3-year and 5-year OS and RFS rates than adult patients. Known congenital colon disease did not contribute to this difference.

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30. THE LATE EFFECTS OF SMOKING: HYPERCAPNIA, AN ELEMENT OF OBSTRUCTIVE RESPIRATORY DISORDERS, CONTRIBUTES TO PANCREATIC CANCER CHEMORESISTANCE AND PROGRESSION

Avinoam Nevler* Charles J. Yeo
Harish Lavu* Jonathan R. Brody*
Theresa P. Yeo*

Background: Chronic obstructive respiratory disorders (ORD) are linked to increased rates of cancer related deaths. Little is known about the effects of hypercapnia (elevated CO₂) on pancreatic ductal adenocarcinoma (PDAC) development and drug-resistance.

Methods: Two PDAC cell-lines were exposed to normocapnic (continuous 5% CO₂) and hypercapnic (continuous/intermittent 10% CO₂) conditions, physiologically similar to patients with active ORD. Cells were assessed for proliferation rate, colony formation and chemotherapeutic efficacy. In a retrospective clinical study, PDAC patients who have undergone pancreatic resection between the years of 2003-2014 were reviewed. Active smokers were excluded in order to remove possible smoking-related pro-tumorogenic influences. Clinical data, histological findings and survival endpoints were recorded. Kaplan-Meier and Cox regression survival analyses were performed.

Results: In-vitro, continuous hypercapnia resulted in an increased colony formation and proliferation rate (P<0.05). Intermittent exposure to hypercapnia resulted in a significant increase in proliferation rates in the both cell-lines (45% increase and 115% increase, P<0.05) and a striking 16-20-fold increase in gemcitabine resistance (P<0.05) (Figure). 582 patients were included [52% males, median age was 68.7 years (IQR 60.6-76.8 years]. Cox regression analysis assessed TNM-staging and ORD status which identified ORD as an independent risk factor for overall survival (HR 1.7, 95% CI 1.2-2.3, P<0.01) (Figure).

Conclusions: PDAC cells exposed to a hypercapnic environment, common to smokers, promoted tumor proliferation and chemoresistance. Retrospective clinical analysis showed that patients with a history of ORD had an overall worse survival rate suggesting that hypercapnic conditions play a role in the development and progression of PDAC.
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.

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Cox regression model in resected PDAC patients assessing relative effects of obstructive lung diseases on overall survival (HR 1.7, 95%CI 1.2-2.3, P<0.01). Side panel – In vitro growth rates and gemcitabine dose-response curves in MiaPaca2 PDAC cell line exposed to normocapnic (continuous 5% CO₂) and hypercapnic (continuous/intermittent 10% CO₂) conditions. MP2 – MiaPaca2.
RISK OF METACHRONOUS COLORECTAL NEOPLASMS IN GERMLINE CONFIRMED LYNCH SYNDROME PATIENTS UNDERGOING A SEGMENTAL COLECTOMY

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Irbaz Hameed* J. Joshua Smith* Philip Paty*
Alexa von Mueffling* Iris Wei* Arnold Markowitz*
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Background: Because of increased risk of metachronous colorectal neoplasia (mCRN), Lynch Syndrome (LS) patients are offered total colectomy. However, rate of mCRN as a function of type of mismatch repair (MMR) mutation is uncertain. We evaluate the prevalence of mCRN according to MMR mutation in LS patients following an index segmental resection (iSR)

Methods: Single center, retrospective cohort study in patients with known LS mutation (MLH1, MSH2, MSH6 or PMS2 genes) followed prospectively in Registry Database. All patients included underwent surveillance colonoscopy. A mCRN was defined as occurring greater than 6 months after index cancer. Primary outcome was rate of mCRN according to MMR mutation. A 5-year cumulative risk for mCRN was calculated using a Kaplan-Meier analysis.

Results: 110 patients were included: 35 MLH1 (32%), 42 MSH2 (38%), 20 MSH6 (18%) and 13 PMS2 (12%). Median number of follow up colonoscopies was 3 (1 to 8). A total of 25 (22%) patients developed a mCRN at a median follow-up of 51 months: 10 (29%) of all MLH1 patients, 11 (26%) MSH2, 3 (23%) PMS2 and only 1 (5%) MSH6 group. During the initial 5 years post iSR, no mCRN were detected in patients with either a PMS2 or MSH6 mutation.

Conclusions: Following an iSR, LS patients with MSH6 mutation are unlikely to develop a mCRN. If validated in multicenter studies, our data support a segmental resection and active long-term surveillance colonoscopy rather than a total colectomy for LS patients with an MSH6 mutation.

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32. **FIRST ASSESSMENT OF THE IMPACT OF CYTOREDUCTIVE SURGERY AND HYPERThERMIC INTRAPERITONEAL CHEMOTHERAPY (CRS+HIPEC) ON THE QUALITY OF LIFE CAREGIVERS AND PATIENTS**

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Konstantinous I. Votanopoulos

**Introduction:** CRS+HIPEC is a formidable procedure, often effecting the quality of life (QOL) of the caregiver as well as the patient. We explored the impact of quality of life and depressive symptom burdens of CRS+HIPEC patients and caregivers prospectively.

**Methods:** Patient and caregiver dyads were both consented per IRB approved protocol. CRS+ HIPEC was performed. The impact on QOL and depressive symptom burdens was assessed on patient-caregivers dyads via Caregiver Quality of Life (CG QOL-C), CES-D instruments; prior to CRS+HIPEC(T1), post-surgical (T2),6(T3),12(T4) months after.

**Results:** 77 dyads were approached with 73 participating. Both caregiver (CG) p=.0008 and patient, p=.0002 depressive symptom trajectories changed significantly (see table). Patient CES-D scores increased between T1 and T2. 0 in depression scores at the post-surgical visit. At T3, both groups dropped to less concerning levels; yet caregiver CES-D scores increased again at T4 4.7 points (SD 12.5) higher than patients. Depressive scores in the possible probable or case levels decreased for both the CG (-15%) and patients (-3%) by the end of the study (T4). Financial concerns for CG decreased over time with scores increasing from T1- 8.3 (.48) to T4- 9.1(.58), p=.0004.

**Conclusions:** Significant numbers of caregivers endorsed high depressive symptom burdens and financial concerns. Different caregiver-patient trajectories reflect the need for differential timing of supportive interventions after CRS+HIPEC. Evaluation of quality of life and impact of CRS+HIPEC procedures must look beyond the patient and include their caregivers as well.

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<th>% depressed</th>
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<td><strong>CG data</strong></td>
<td><strong>CESD (SE)</strong></td>
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<tr>
<td>Pre-trt</td>
<td>15.1 (1.7)</td>
</tr>
<tr>
<td>Post-surgical</td>
<td>15.0 (1.4)</td>
</tr>
<tr>
<td>Month 6</td>
<td>10.3 (1.4)</td>
</tr>
<tr>
<td>Month 12</td>
<td>13.1 (2.1)</td>
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<th><strong>Patient data</strong></th>
<th><strong>CESD (SE)</strong></th>
<th>p-value</th>
<th>possible</th>
<th>probable</th>
<th>case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-trt</td>
<td>10.2 (1.1)</td>
<td>p=0.0002</td>
<td>7%</td>
<td>7%</td>
<td>2%</td>
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<tr>
<td>Post-surgical</td>
<td>13.7 (1.4)</td>
<td></td>
<td>20%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Month 6</td>
<td>9.0 (1.2)</td>
<td></td>
<td>9%</td>
<td>3%</td>
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<tr>
<td>Month 12</td>
<td>10.3 (1.5)</td>
<td></td>
<td>0</td>
<td>13%</td>
<td>0</td>
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</table>
Background: The presence of distant metastasis in colorectal cancer (CRC) plays a significant role in disease progression, treatment course, and prognosis. The most common sites of metastasis are the liver and lung. Surgical resection is standard of treatment for liver or lung metastasis, but best-practice guidelines still differ. Evidence regarding management of simultaneous liver and lung metastasis (SLLM) is conflicting, with prior studies limited by small sample sizes.

Methods: Adults from the National Cancer Database (2010-2015) with primary diagnosis of colorectal liver, lung, or SLLM were included and stratified by metastasis site. The primary outcome was 5-year overall survival (OS), analyzed using Kaplan-Meier survival curves, log-rank test, and the Cox proportional hazards models.

Results: Among 82,609 included patients, 70.42% had liver, 8.74% lung, and 20.85% SLLM. Chemotherapy alone treatment was the most utilized (21.11%), and chemotherapy with combined colorectal radical resection (CRRR) and liver/lung resection (L/LR) was utilized in 8.22% of cases. Patients with lung metastasis had significantly better 5-year OS (liver: 15.99%; lung:16.70%; SLLM: 5.51%; p<0.001) than other metastatic groups. Chemotherapy with CRRR and L/LR was associated with the greatest reduction in mortality risk in unadjusted (figure) and adjusted analyses (chemotherapy alone-ref; liver: HR 0.42, 95% CI 0.38-0.47, p<0.001; lung: 0.31, 0.18-0.53, p<0.001; SLLM: 0.80, 0.32-1.02, p=0.077) while forgoing treatment or CRRR alone offered the worst OS.

Conclusions: CRC patients with metastasis to lung had increased OS compared to other sites, regardless of treatment. Resection of primary tumor, metastasectomy, and chemotherapy appears to offer the greatest chance of survival for liver, lung, and SLLM patients, and should be considered to improve OS.

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Figure. Five-year overall survival rates for colorectal cancer patients with liver, lung or both metastases, stratified by treatment type. CRRR= Colorectal Radical Resection; L/LR=Liver/Lung Resection.
Background: The natural history of hiatal herniation of small and/or large bowel post esophagectomy (HHBPE), in the current era of improving long term survival and evolving surgical technique, is unknown. The aim of this study is to describe the rate and risk factors of HHBPE at our hospital.

Methods: Patients undergoing esophagectomy between January 2011 and June 2017 were included if both follow up information and axial imaging were available beyond 3 months post esophagectomy. Patient characteristics, disease information, and treatment factors were all included in univariate analysis comparing patients with and without HHBPE, and multivariate regression was used to identify significant independent risk factors associated with HHBPE.

Results: Out of 310 esophagectomy patients, 258 met inclusion criteria, with 79 (31%) showing evidence of HHBPE and an overall median follow-up of 24 months; 44/79 (56%) had symptoms possibly referable to HHBPE and 17/79 (22%) underwent surgical repair. On univariate analysis, neoadjuvant therapy (N=176), higher clinical stage, minimally invasive approach (N=154), and transhiatal esophagectomy (N=189) were significant predictors of HHBPE (p<0.05). On multivariate analysis, neoadjuvant therapy and transhiatal approach remained significant independent predictors (p<0.05). In the 131 patients (51%) that had both factors, the rate of HHBPE was 44%.

Conclusions: HHBPE in the current era of neoadjuvant therapy and minimally invasive esophagectomy is common. HHBPE may cause GI symptoms but operation to repair HHBPE is uncommon on intermediate follow up. Further study and long term follow up are required to fully assess the impact of HHBPE and to potentially modify surgical practice to prevent or minimize HHBPE.
35. REGIONAL THERAPY WITH NOVEL CHIMERIC IMMUNO-ONCOLYTIC VIRUS, CF33-ANTI-RD-L1, FOR PANCREATIC ADENOCARCINOMA WITH PERITONEAL CARCINOMATOSIS IS MORE EFFECTIVE THAN SYSTEMIC TREATMENT

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Yuman Fong

**Introduction:** Peritoneal carcinomatosis (PC) from pancreatic ductal adenocarcinoma (PDAC) is common and fatal. Our preclinical study presents an effective treatment against PDAC PC employing a novel oncolytic viral agent, CF33 engineered to express the immune check point inhibitor anti-program death ligand -1 (PD-L1) antibody.

**Methods:** CF33 is an artificial genetically engineered orthopoxvirus that expresses anti-PD-L1 antibody (CF33-anti-PD-L1). In vitro ability of this virus to kill five PDAC cell lines were tested at various doses (multiplicity of infection =0.01, 0.1, 1, 10). Anti-PD-L1 antibody production by virus infected cells and blockade function were tested (western blot and bioassay, respectively). We also tested baseline and post-infection PD-L1 expression by PDAC cells (flow cytometry). In vivo models of PC created by injecting ASPC-luc cells in nude mice were treated either with single dose (5x10^5 pfus) of intraperitoneal (n=7) or intravenous (n=8) CF33-anti-PD-L1 and compared to PBS controls for size of tumor and survival.

**Results:** CF33-anti-PD-L1 killed PDAC cell lines in a dose dependent manner reaching >90% cell kill by day 8 regardless of dose. All cell lines possessed target for anti-PD-L1 treatment as shown by expression of PD-L1 on the cell surface or in the cytosol. Virus infection further increased baseline PD-L1 expression. Virus induced the production of bioactive anti-PD-L1 antibody by infected PDAC cells. In vivo, mice xenografts treated with single IP or IV dose of CF33-anti-PD-L1 or PBS revealed the greatest decrease in tumor burden in the IP Group at 2, 3, and 4 weeks (p<0.05, p<0.01, and p<0.01, respectively). We also showed preferential viral targeting to tumor with minimal virus found in normal organs.

**Conclusions:** CF33-anti-PD-L1 is effective in infecting and killing human PDAC and produce functional anti-PD-L1 antibody. Intraperitoneal delivery of CF33-anti-PD-L1 is very effective in decreasing peritoneal tumor burden after only one dose and superior to IV delivery.
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