Abstracts

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- <0.001), male sex (OR 1.45,
- <0.001), alcohol use (OR 1.18,
- <0.001), hypertriglyceridemia (OR 1.56,
This is the largest series to date describing the endoscopic and pancreatographic findings
Acute pancreatitis is the leading gastrointestinal cause of hospitalization in the United
- <0.001) and underlying liver
- <0.001) Among patients
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- 37x21]

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Frequency of Appropriate Use of Pancreatic Enzyme Replacement Therapy (PERT) and
Symptomatic Response in Pancreatic Cancer Patients
Lola Rubbi, PhD1, Amy Westermann, PhD2, Jodie A. Barkin, MD1, William Heos, MBA1, Casadei
Minnaruk1, BS, Lynn Matravish, PhD, MBA1, Hongwei Wang, MS1, Lynn Shemanski, PhD2, Jamie S.
Barkin, MD1, MACG1, MACAG1, FASGE1. Pancreatic Cancer Action Network, Manhattan Beach,
CA;1 University of Miami Miller School of Medicine, Miami, FL;2 Cancer Research and Biostatistics,
Seattle, WA

Introduction: Pancreatic cancer (PC) and its treatments can result in pancreatic exocrine insufficiently that requires pancreatic enzyme replacement therapy (PERT). Appropriate PERT usage is during meals and snacks. The aim was to determine the frequency of appropriate use of PERT and its impact on symptom alleviation in PC through a patient reported outcomes online platform.

Methods: Users who enrolled in the Pancreatic Cancer Action Network’s Patient Registry (launched January, 2016) were prompted to answer a standalone 25 part questionnaire about their experience with PERT. In May 2016, 5 supplementary questions were added to capture additional symptoms and side effects.

Results: 136 users completed the enzymes questionnaire by March 2017 (33 prior to addition of the 5 questions). The median age at registry enrollment was 63 (Range 23-88), 62 (48%) were female, while 34 did not report gender. Seventy percent of patients reported having adenocarcinoma, 9% neuroendocrine, 21% reported other types or unknown. 85 (63%) had surgery, 59 (43%) had radiation therapy, and 312 (82%) had chemotherapy. 115/136 (84%) reported speaking to a healthcare professional about PERT and 104/135 (90%) were prescribed PERT. 68/104 (65%) reported that PERT was prescribed with all meals and snacks, of which 44/68 (65%) reported compliance. There were 63 responses about PERT timing, of which 40 (63%) took PERT with meals, 19 (30%) prior to meals, and 4 (6%) after meals. Patients who reported taking PERT with meals had higher alleviation of symptoms. ‘Feeling of indigestion’ and ‘Increased or foul smelling flatus’ were significantly decreased when taking PERT with meals compared to those taking PERT prior to or after meals (P=0.005 & P=0.04 respectively). Though not statistically significant, there was a trend that patients taking PERT with meals were less likely to report ‘Frequent stools’, ‘Loose stools’, and ‘Visible food particles in stool’ compared to taking PERT prior to or after meals. Patients taking PERT with meals reported weight gain and less weight loss.

Conclusion: Of the 76% of PC patients prescribed PERT, 65% were prescribed PERT appropriately with all meals & snacks. Overall compliance with PERT administration guidelines was low (38%, 44/104). Improvement in symptoms significantly correlated with appropriate use of PERT. Increase in PC patient and provider education about appropriate PERT usage and administration is warranted.

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Incidence and Outcomes of Acute Respiratory Distress Syndrome in Patients With Acute Pancreatitis
Hesika Balagum, MD1, Vikes Koppurupa, MD2, Kehiti Chatterjee, MD2, Pooja Guaram, MD1, Abhinav Goyal, MD1, Chabir Adreddy, MD1, Mark F. Young, MD1. East Tennessee State University, Johnson City, TN;1 University of Arkansas for Medical Sciences, Little Rock, AR;2 Einstein Medical Center, Philadelphia, PA

Introduction: Acute pancreatitis is the leading gastrointestinal cause of hospitalization in the United States. Severe pancreatic damage leads to systemic inflammatory response syndrome (SIRS) and affects multiple organs including lungs, the severe form of which is acute respiratory distress syndrome (ARDS). We seek to analyze the incidence and in-hospital mortality in ARDS associated with pancreatitis. We also analyzed the predictors associated with development of ARDS and the predictors of in-hospital mortality in these patients.

Methods: Using the National Inpatient Sample 2003-2013, we identified adults (age>18 years) admitted for acute pancreatitis with ICD-9-CM code 577.8. Among these patients, ARDS was identified by ICD-9 code 518.82. Patients with missing data for age and gender were excluded. To identify the predictors associated with development of ARDS, we created a multivariate logistic regression model with covariates including demographics, Elixhauser comorbidities, and etiology of pancreatitis (alcohol/gallstone/hypertriglyceridemia). In-hospital mortality and length of stay (LOS) among these patients was studied. Predictors of in-hospital mortality were examined using similar multivariate logistic regression.

Results: Between 2003-2013, there were a total of 2,787,590 hospitalizations for acute pancreatitis. Among these, 6,163 (0.2%) developed ARDS. The independent predictors for development of ARDS in these patients were age >65 (OR 1.52, P<0.001), male sex (OR 1.45, P<0.001), alcohol use (OR 1.18, P<0.001), hypertriglyceridemia (OR 1.56, P<0.001) and obesity (OR 1.43, P<0.001). Among patients with acute pancreatitis and ARDS, the mean age (SD) was 55.6 (17.6) years and 60.4% were males. Median LOS was 11 days and the in-hospital mortality was 11.4%. The independent predictors of in-hospital mortality were age >65 (OR 3.93, P<0.001), male sex (OR 1.80, P<0.001) and underlying liver disease (OR 1.79, P<0.001).

Conclusion: We noticed that the incidence of ARDS is low among individuals with acute pancreatitis and the mortality of ARDS in pancreatitis is 11%, which is lower than the mortality of ARDS from other disease processes. We also noticed that older males are more likely to develop ARDS and have higher incidence of in-hospital mortality. Furthermore, alcohol use, obesity and hypertriglyceridemia are associated with increased incidence of ARDS and underlying liver disease is associated with increased in-hospital mortality.

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Surgery versus Conservative Management After Endoscopic Retrograde Cholangiopancreatography (ERCP) for Biliary Stone Disease in High-Risk Veterans
Sammirah Patel, MD1, Dnyaneshwar R. Kohli, MD2, Jeannie Savas, BS, MD1, Pritesh Mudha, MD3, Akvin Zamin, MD1, MACG1, Tilak Shah, MD1,2.1 Virginia Commonwealth University, Richmond, VA;2 Hunter Holmes McGuire VA Medical Center, Richmond, VA;3 Hunter Holmes McGuire VA Medical Center, Richmond, VA

Introduction: In otherwise healthy patients, randomized trials demonstrate reduced mortality with cholecystectomy (CCY) when compared to conservative management after endoscopic retrograde cholangiopancreatography (ERCP) for biliary stone disease. These studies generally exclude older patients with comorbidities at increased risk of post-operative complications. Our study assessed the benefit of CCY among older veterans with significant comorbidities.

[50] CCI Charlson comorbidity index; ASA American Society of Anesthesiologists; NSQIP National Surgery Quality Improvement Program.