utilization. Patients with morbid obesity (OR=0.52; CI: 0.30-0.90) and those with choledolithiasis/choledochocholangitis (OR=0.67; CI: 0.37-0.81) were less likely to be high utilizers.

Conclusion: About one in twenty patients with AC are high healthcare utilizers. CCI of 4-6, admission to a metropolitan teaching hospital and disposition as home health care were associated with high health care utilization. Further studies are needed to understand the reasons and develop strategies to help reduce the costs and improve outcomes in these subgroup of patients.

Table 2. Multivariable Analysis of Factors Associated with High Utilization

<table>
<thead>
<tr>
<th>Factor</th>
<th>OR (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-6 vs. 0-3</td>
<td>1.05 (0.82, 1.38)</td>
<td>0.59</td>
</tr>
<tr>
<td>Teaching status of urban hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metropolital vs. Metropolitan non-teaching</td>
<td>1.3 (0.94, 1.7)</td>
<td>0.06</td>
</tr>
<tr>
<td>Hospital care vs. Routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-cholecystitis or cholecystitis</td>
<td>0.52 (0.50, 0.50)</td>
<td>0.20</td>
</tr>
</tbody>
</table>

49_C Figure 3. Multivariable Analysis of Factors Associated with High Utilization

50 Clinical Implications and Cost Effectiveness of Index Admission Cholecystectomy in Acute Biliary Pancreatitis: A Study in a Inner City Minority Populations

Tajger Sundaresan, MD, Christopher Bonna, MD, Prashanth Rawle, MD, Andrew Ofiu, MD, MPH, Eric O. Thun, MD, Vibhavithi Dadanai, MD, Tine Wexler, MD, Sabrina Bonna, MD, Andrea Calliff, MD, Vinaya Gaduputi, MD, Zhou Z. Shen, MD. The Brooklyn Hospital Center, Clinical Affiliate of The Mount Sinai Hospital, Brooklyn, NY. 2, SHH Health System, Bronx, NY, 3, Memorial Hospital of Martinsville and Henry County, Martinsville, VA, 4, The Brooklyn Hospital Center, Brooklyn, NY

Introduction: Alcohol and gallstones account for over 80% of acute pancreatitis (AP). The timing of cholecystectomy after an attack of acute biliary pancreatitis (ABP) is controversial. Those diagnosed with mild AP are recommended to have cholecystectomy before discharge to prevent recurrence. We conducted a single center retrospective study on patients with AP secondary to gallstones/micro lithiasis addressing the impact of early same-admission cholecystectomy (SAC) on recurrence of AP, healthcare costs and readmissions to hospital when compared to delayed cholecystectomy (DC).

Methods: We performed a chart review of 350 patients admitted with diagnosis of AP. Study population (n=57) included those diagnosed with ABP. Patients who were classified as having severe AP with possible etiologies other than biliary causes and those who underwent prior cholecystectomy were excluded from the study. The primary aim of the study was to look at the impact of SAC on preventing recurrence of AP and readmissions to the hospital - when compared to DC. Statistical analysis included: t-test analysis for continuous variables and fisher exact test for categorical variables. (Table 1)

Results: The study population was split into 2 groups: SAC group (n=27) and DC group (n=30). The average length of stay in the SAC group was 6.30 SD±2.65 days while it was 5.92 SD±3.96 days in the DC group (p-value 0.6755). The average cost of the index admission in SAC group was $43,478.67, while it was $49,750.20 in DC group (p-value 0.6755). The average cost of the index hospitalization for these patients was 129.6 days. Those who had been readmitted had average length of the stay of 24 days. None of the patients in the SAC group had readmissions for AP, while 5 patients in the DC group were admitted to the hospital with recurrent AP. The average time to readmission for those patients was 129.6 days. Those who had been readmitted had average length of the stay of 3 days, with an average cost of the readmission of 21,739.34 dollars per patient.

Conclusion: Our study focused on clinical implications of performing index admission cholecystectomy as compared to deferring them to be done as an outpatient. There had been no episodes of recurrent AP in SAC group. Alternatively, among those who had been referred for outpatient cholecystectomy- 18% were readmitted with recurrent pancreatitis requiring an in-hospital stay of 3 days on average. We suggest performing index admission cholecystectomy reduces the rate of admission for recurrent AP, overall morbidity and healthcare costs.

51 A Population-Based Cohort Study of National Trends in Hospital Admissions for Alcohol and Non-Alcohol-Related Acute Pancreatitis Over an 8-Year Span

Monica Saumoy, MD, MS; Russell Rosenblatt, MD; Shweta Shah, MD; Akseyy Novikov, MD; Kaveh Hajifathalian, MD; David L. Carr-Locke, MD, FACG; Room Z. Shamsa, MD, MSc. 1. New York Presbyterian Hospital, New York, NY; 2. New York Presbyterian Weill Cornell Medical Center, New York, NY; 3. New York Presbyterian-Weill Cornell Medical Center, Philadelphia, PA; 4. New York Presbyterian; New York, NY; 5. Weill Cornell Medical College @ New York Presbyterian Hospital, New York, NY; 6. New York Presbyterian Hospital/Weill Cornell Medical College, New York, NY

Introduction: Hospitalizations for acute pancreatitis are associated with significant health care utilization. However, improvements in managing pancreatitis has led to an overall decrease in mortality. It remains unknown whether there is a similar trend in patients with alcohol-related pancreatitis. The aim of this study was to examine the trends in hospitalization characteristics comparing alcohol to non-alcohol related pancreatitis.

Methods: Using the Nationwide Inpatient Sample (NIS) database, we identified administrative data for hospital discharges in the US between 2007-2014. We identified acute pancreatitis admissions by finding all hospital admissions with a primary ICD-9 diagnosis code of 577.0 (acute pancreatitis). We identified those with concurrent alcohol-related disorders while excluding those with pancreatic cancer. All admissions were analyzed for the primary outcome of mortality, as well as secondary outcomes of need for inpatient ERCP or cholecystectomy; average length of stay and average total charges.

Results: There were a total of 3,317,851 weighted hospital discharges with a primary diagnosis code of acute pancreatitis over the 8-year period. There was a steady increase in the overall number of inpatient admissions for acute pancreatitis (p<0.01). There was a significant increase in the proportion of admissions for acute pancreatitis with a concomitant alcohol disorder over the study period (from 23.5% in 2007 to 27.6% in 2014, p<0.01). The mean overall length of stay decreased from 6.8 to 7.5 days (p<0.05), and patients with alcohol-related pancreatitis had an even lower length of stay by 1 day (p<0.01). Furthermore, rate of inpatient mortality from acute pancreatitis decreased overall (p<0.01), and alcohol pancreatitis appeared to be protective of inpatient mortality as compared to non-alcoholic pancreatitis (p<0.01). In multivariable analysis to predict inpatient mortality, alcohol use was associated with a decreased odds of mortality (0.57, 95% CI 0.542-0.604). Mean total charges per admission for non-alcohol related pancreatitis was $494 as compared to $343K per admission for alcoholic pancreatitis (p<0.05).

Conclusion: Inpatient hospitalizations of acute pancreatitis over the past 8 years have increased but with lower rates of inpatient mortality and length of stay, presumably from early diagnosis and initiation of treatment. Of interest, alcohol-related pancreatitis appears to be associated with a lower length of stay and mortality.

52 Expeditied Inpatient Work-Up for Suspected Non-Metastatic Pancreatic Cancer Is Associated With Greater Resource Utilization but Questionable Clinical Benefit

Robert Schrock, MD; Ajay Singhvi, MD; Rajesh Kewani, MD, MS; Feinberg School of Medicine, Northwestern University, Chicago, IL

Introduction: Pancreatic cancer (PC) is associated with high mortality with survival rates related to stage at diagnosis. Despite unclear benefits and added costs, physicians may admit patients with potentially resectable PC to the hospital as expedite endoscopic work-up. We aimed to determine 1) predictors, resource utilization, and 3) outcomes of initial inpatient (IP) vs. outpatient (OP) work-up of suspected PC.

Methods: This was a retrospective cohort study of patients who underwent EUS +/- ERCP for suspected non-metastatic PC at a single tertiary care medical center over 54 months (4/2011-10/2015). Main chart review was conducted to collect demographics, laboratory and imaging studies, and outcomes data. Results: Of 367 patients who underwent EUS for evaluation of suspected PC, 102 were excluded due to outside hospital transfer or suspected metastatic disease. Of the remaining 265 patients, 171 (65%) underwent initial OP and 94 (35%) initial IP endoscopic work-up of non-metastatic PC. Suspected PC patients managed as an IP were less likely to have a primary care provider (Odds Ratio [OR] 0.2, 95% Confidence Interval [CI] 0.1-0.4) or private insurance (p=0.02). IP were more likely to be ASA class ≥3 (OR 3.3, CI 2.4-4.3) with a greater likelihood of leukocytosis (OR 2.9, CI 3.1-4.6), renal insufficiency (OR 3.4, CI 1.4-8.2), and elevated bilirubin (mean 8.2 vs 3.1 mg/dL, p<0.01). (Table 1). The median hospital length of stay for IPs was 6.5 days (range 1-35) vs 2.5 days (range 1-35). IP underwent more imaging studies (median vs. 1, p<0.01) and were more likely to require ERCP (OR 3.5, CI 1.5-8.1). There was no difference in the rate of procedure-related adverse events. The time from suspected malignancy to EUS was shorter for IPs (median 3 vs. 13 days, p<0.01). IP were less likely to have resectable disease (OR 0.3, CI 0.2-0.5) and had increased mortality at both 30-days (6% vs. 3%) and 90-days (15% vs. 6%). Conclusion: Patients with suspected non-metastatic PC admitted to the hospital for work-up are sicker and less likely to have a primary care provider. “Expedited” in-patient work-up minimally reduces time to diag.