INTRODUCTION: Pancreatic diseases, mainly pancreatic cancer, can result in a significant portal vein (PV) and superior mesenteric vein (SMV) stenosis, which in turn leads to all the complications associated with portal vein stenosis due to pancreatic diseases.

METHODS: In April 2020, we searched English language case series and case reports using PubMed, Scopus, Google Scholar, MEDLINE, ScienceDirect, CINAHL, Complete, and Cochrane Library. Search keywords included but not limited to pancreatic cancer/adenocarcinoma, pancreatitis, portal vein, superior mesenteric vein, stenosis, and stenting. Inclusion criteria included transpapillary (PT) or percutaneous transhepatic (PT) stenting of non-transplant PV/SMV stenosis secondary to pancreatic cancer or pancreatitis, excluding liver and hepatic malignances.

RESULTS: Twenty case series and case reports of 61 patients met the inclusion criteria. The studies were published between 1993 and 2019. The age of patients was between 22 and 86 years (average 63) with male predominance (60%). The most presenting symptoms included ascites and melena. The vast majority of patients had PV stenosis. Most of the cases had pancreatic cancer status post pancreateoduodenectomy (98%) as the etiology of PV/SMV stenosis. PT venoplasty was performed in 68%, while the TI approach in the remaining 32%. Portal venous pressure gradient (PVPG) was measured in 31 patients and was lowered from an average of 12.3 mmHg to 1.7 mmHg. Most of the patients had a high technical success rate and achieved symptomatic relief. Stent patency rate was widely variable 20 days to 7 years.

CONCLUSION: PV stenting is a widely accepted method to improve portal hypertension symptoms in the setting of liver transplantation. In non-transplant patients, TI and PT stenting of PV/SMV stenosis have only been reported in case reports/case series with a small number of patients. Thus, their efficacy remains unclear. In this abstract, we specifically reviewed the utility of stenting of PV/SMV stenosis in the setting of pancreatic pathology. Results demonstrated relief of portal hypertension-related symptoms and improvement of the quality of life. The drop in PVPG can be used as a measurable tool to demonstrate improved outcomes. Per our literature review, this is the first report reviewing the stenting of PV/SMV stenosis due to pancreatic disease. Further studies are needed to determine the efficacy and safety of these procedures.

REFERENCES
In our nationwide analysis, we sought to analyze the impact of obesity on various outcomes for patients hospitalized with AP in the United States.

METHODS: We queried the National Inpatient Sample (NIS) databases 2016 and 2017 using the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) coding system to identify the patients with primary diagnosis of Acute Pancreatitis and a secondary diagnosis of obesity. Analysis was performed using STATA software.

RESULTS: 575,229 adult patients with AP were included in the study. Mean age was 51.9 years, and majority of patients were male (53.12%). 97,265 (16.91%) patients had a secondary diagnosis of obesity. The total mortality in patients with obesity was 0.95% and in patients without obesity was also 0.59%. There was no significant difference in all cause in-hospital mortality between patients with obesity compared to patients without obesity (aOR 1.01, 95% CI: 0.94–1.08, P = 0.64). Mean LOS was 4.83 days (95% CI: 4.75–4.92) in obese patients and 4.22 days (95% CI: 4.19–4.26) in non-obese patients. The mean adjusted difference in total hospitalization charges was $ 8,177 (95% CI: $6,765–$9,589, P < 0.01), and the mean adjusted difference in total hospitalization costs was $ 1,888 (95% CI: $1,385–$2,190, P < 0.01). Obese patients had higher likelihood of shock (aOR 1.35, 95% CI: 1.32–1.82, P < 0.01), sepsis (aOR 1.49, 95% CI: 1.38–1.62, P < 0.01), AKI (aOR 1.22, 95% CI: 1.16–1.28, P < 0.01), ICU admission (1.95% vs 1.23%, aOR 1.56, 95% CI: 1.37–1.77, P < 0.01).

CONCLUSION: We found that obesity had a significant impact on hospital outcomes of AP. They were more likely to suffer from AKI, sepsis, and shock, and were more likely to be admitted to the ICU. This possibly implies that they are more likely to suffer from moderately severe and severe AP. This is consistent with previous meta analyses which showed that obesity was a strong risk factor for severe AP and local and systemic complications. Future studies are needed to examine the effect of obesity on mortality in patients with AP in the United States.

[41] Figure 1. Outcomes in patients with and without obesity in Acute Pancreatitis.

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Real World Practices of Same-admission Cholecystectomy in Gallstone Pancreatitis
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INTRODUCTION: Cholecystectomy performed during an admission for gallstone pancreatitis (GP) has been reported to reduce both length of stay (LOS) and future encounters without causing an increase in complications. Despite this, rates of cholecystectomy remain low. To understand real-world trends of patients who underwent cholecystectomy after diagnosis of GP, we characterized their rates, risks, benefits, comorbid conditions, location of care and contrasted them across a nine-hospital system.

METHODS: ICD-10 codes were used to retrieve charts of patients presenting to the MedStar Health between March 2015 and June 2019. These included emergency department visits and inpatient admissions. Charts meeting Revised Atlanta Classification for acute pancreatitis (AP) were retrieved. Charts that carried a diagnosis of GP were put into two groups, 1) Those that underwent same-admission cholecystectomy (SAC) and 2) Those who did not. Those groups were then compared for the following variables: LOS, future encounter and complication rates, location of care, history of cholecystitis or cholelithiasis and presence of hypertension, coronary artery disease, congestive heart failure, asthma/chronic obstructive pulmonary disease, smoking status, chronic liver disease or carcinos. Statistical analysis was performed using GraphPad PRISM.

RESULTS: 1722 of 2541 charts met criteria for AP, 366 of which carried a diagnosis of GP. LOS was observed to be greater in those who underwent SAC when compared to those who did not (5.5 vs 4.2 days, 95% CI 0.26–2.26, P = 0.0138). Patients at tertiary centers were observed to have been less likely to undergo SAC (31.4% vs 44.5%, OR 0.570, P = 0.0151). There was no significant difference in rates of future encounters or complications, presence of comorbidities or history of either cholelithiasis (50.0% vs 48.4%, P = 0.831) or cholecystolithiasis (76.4% vs 86.0%, P = 0.847) between the two groups.

CONCLUSION: In patients with GP, SAC was associated with increased LOS. Despite the association between cholecystolithiasis or cholelithiasis and GP, there was no correlation between SAC and history of these prior conditions. This lower rate of SAC at tertiary centers could reflect a lack of penetrance of guideline adherence. Given these findings, the balance between benefit and risk remains to be one that warrants careful consideration and further investigation.

[42] Figure 1. Characteristics of study population.