RESULTS: 103 DM patients (93.2% type-2; 6.8% type-1) had mean age and BMI of 64.9 ± 14 years, and 31.6 ± 9.2 respectively, of which 61.2% (63/103) were females. Average duration of DM in this cohort was 9.6 ± 6.2 years, with mean HbA1c of 7.7 ± 1.9%. The odds of finding any minor Rosemont minor criteria on EUS in DM patients presenting with abdominal pain were 3.2 times higher in male gender (95% CI: 1.4-7.5) and 3.3 times higher with history of alcohol use (95% CI: 1.3-8.4). All other variables tested in univariate analysis (age ≥65, race, ethnicity, diabetes duration >10 years, HbA1c ≥6.5, presence of diabetes complications, tobacco use, reason for EUS being exclusively unexplained abdominal pain) had no statistically significant association with the finding of any minor Rosemont criteria on EUS. In binary regression model, male gender (OR = 4.1; 95% CI: 1.5–11.3, P = 0.005), history of alcohol use (OR = 43, 95% CI: 1.4–13.9, P = 0.013) and BMI ≥30 kg/m² (OR = 4.95; CI: 1.3–12, P = 0.013) were most predictive of the finding any minor Rosemont criteria on EUS in patients with DM irrespective of procedure indication.

CONCLUSION: Pancreatic parenchymal and ductal abnormalities not meeting Rosemont criteria diagnostic of CP appear to be present in patients with DM. In our cohort, one patient met required Rosemont criteria for CP and 35.9% (37/103) had one or more minor Rosemont feature in their EUS. Alcohol use and male gender are independently associated with the presence of any of the Rosemont criteria.

S0095

Acute Pancreatitis in Young Adults: Morbidity, Mortality, and Hospital Utilization
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INTRODUCTION: Acute Pancreatitis is a common cause of gastrointestinal morbidity and mortality in the United States. Common etiologies include biliary disease, alcohol, post-ERCP, drug-related, and trauma. Varying demographics accompany the different etiologies, yet there is a paucity of data on outcomes of AP in YA. In this study, we aim to identify mortality, morbidity, hospital utilization, and prevalence of young adults with AP.

METHODS: In the Nationwide Inpatient Sample database (years 2003-2014), adults >18 years old who were hospitalized for AP were identified. We divided cohort into young adults (18-35 years) and older adults (>55 years). Univariate analysis was performed by chi-square, t-test to find out demographic characteristics, length of stay (LOS), hospitalization cost, mortality, morbidity and complications. Weighted multivariable logistic regression analysis was performed to evaluate predictors of AP and complications among YA and odds of mortality, morbidity, and complications. Models were adjusted for race, sex, Charlson’s Comorbidity Index, payer, teaching hospital, size and teaching status.

RESULTS: A total of 2,632,309 patients were admitted with AP between 2003 and 2014. 60.39% were in young adult category. The inpatient prevalence of AP in YA from 2003 to 2014 was 59.3% to 60.56% for total AP, 45.4% to 45.93% for biliary etiology, and 84.1% to 79.25% for alcohol related, respectively (P trend= 0.001) (Graph 1). Young adults had decreased total charges ($29,004 vs $35,915, p < 0.0001) and LOS (4.86 vs 5.70 days, p < 0.0001). YA were associated with decreased prevalence of mortality (0.4% vs 1.85%, p < 0.0001), morbidity (1.96 vs 5.71, P < 0.0001), major/ extreme disability (23.87% vs 38.76%, p < 0.0001). On regression analysis YA were associated with lower prevalence and odds of complications ie acute renal failure (10.4% vs 4.92%; aOR: 0.67; CI: 0.65–0.69), shock (1.07% vs 0.48%; aOR: 0.55; CI: 0.31–0.81), SIRS/sepsis (3.1% vs 2.2%; aOR: 0.75; CI: 0.72–0.79), pleural effusion (0.15% vs 0.09%; aOR: 0.64; CI: 0.52–0.79), and respiratory failure (4.26% vs 2.09%, aOR: 0.59; CI: 0.56–0.61) (Table 1).

CONCLUSION: Young adults with AP were associated with decreased mortality, morbidity, and complication rate. Prevalence remained consistent among various etiologies over 2003–2014, however alcohol was an overwhelming etiology. Young adults were associated with decreased hospital costs and LOS. More research is needed to combat the high rates of AP due to alcohol abuse in this population.

S0096

Differences in Genomic Mutations in Precancerous Pancreatic Cysts Between African Americans and Caucasians
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INTRODUCTION: Intraductal papillary mucinous neoplasms (IPMNs) are one of the recognized precursors of pancreatic ductal adenocarcinoma (PDAC). Detection of precancerous and early stage neoplastic lesions is critical given the poor 5-year survival rates of PDAC. Although malignant transformation occurs in the minority of lesions, those that do transform are more likely to have high-risk genomic mutations. Next generation sequencing (NGS) identifies IPMNs with these high-risk mutations. African Americans have a higher incidence of PDAC than Caucasians. Multiple factors have been identified that partly explain this difference. However, genomic variability in IPMNs between races has not been studied. Aim: Evaluate differences in high-risk genomic mutations in IPMNs between African Americans and Caucasians.

METHODS: Single institution retrospective cohort study identifying 94 consecutive patients in 2019 who underwent 100 EUS with FNA or ERCP with fluid sampling of pancreatic cysts or pancreatic duct dilation. Indication for diagnostic sampling was based on standard high-risk criteria by ACG guidelines. All cyst fluid was sent for NGS with PancroSeq®. Presence of GNAS and/or KRAS mutation confirmed diagnosis of IPMN. High-risk genomic mutations were TP53, PIK3CA, AKT1, PTEN and SMAD4. Clinical demographics and cyst variables were collected: age, gender, race, BMI, history of pancreatitis, diabetes, smoking, family history of PDCA, cyst size, nodules, duct dilation, CEA level and genomic profile. Differences between African Americans and Caucasians compared with univariate analysis, P < 0.05 significant. Logistic regression for presence of high-risk mutations performed, P < 0.05 significant.

RESULTS: 53 samples were positive for a GNAS and/or KRAS mutation in 49 patients. Seven of 53 samples (12%) had a high-risk mutation. On univariate analysis, clinical and cyst variables did not differ by race. The rate of high-risk mutations did not differ. 29% in African Americans vs 11% in Caucasians (P = 0.197). However, there was a trend toward increased rate of high-risk mutations in African Americans on logistic regression when controlling for
Cholecystitis

CONCLUSION: Higher rates of high-risk genomic mutations in IPMNs might be a factor in explaining the higher rates of PDAC in African Americans. Larger studies are needed to evaluate these findings.

S0097

Is Human Immunodeficiency Virus Associated With Pancreatic Cancer?

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INTRODUCTION: Pancreatic cancer is the fourth most common cause of cancer-related death in the United States (US). Despite recent advancements, the 5-year survival rate of this highly malignant neoplasm is still 9%. The association of exocrine pancreatic adenocarcinoma (EPA) with infectious etiologies has not been well-explored. In this abstract, we will discuss the association of EPA with HIV in patients with and without AIDS-defining illness.

METHODS: We used the 2009 to 2014 nationwide inpatient sample database (NIS) for this study. NIS is the largest publicly available all-payer inpatient database in the US that >7 million hospital stays each year, as a part of the Healthcare Cost and Utilization Project (HCUP). International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes for HIV infection (ICD-9 V08, 042 codes) and EPA subtypes (ICD-9 1570, 1571, 1572, 1578, 1579) were obtained. Logistic regression was used to model the association between EPA of the head, body, tail or combined EPA and HIV infection (asymptomatic and with defining illness patients). Participants included in this study were aged 18 years and above.

RESULTS: From 2009 to 2014 there were 109,566 patients identified with EPA. The mean age of diagnosis was 67 years. The female to male ratio was 1.46:1 with most of the patients being white (68.5%). Regardless of the specific anatomic site, EPA is significantly lower in patients with asymptomatic HIV infection and HIV defining illness (P < 0.001). Using logistic regression, this negative association is independent of age, sex, race, diabetes, smoking status, obesity, and insurance type (Table 1). When subtypes of EPA based on location were considered, EPA of the head is negatively associated with both asymptomatic HIV infections and HIV defining illnesses, while EPA of the body and tail are not associated with HIV (Table 1).

CONCLUSION: Various mechanisms of oncogenic pathogenesis in HIV patients have been proposed, including chronic inflammation and immune system dysregulation. Literature was noted to be sparse in analyzing the relationship between EPA and HIV infection. In this abstract, EPA of the head is less likely in patients with HIV, compared to non-HIV patients. This relationship is unexplained, perhaps due to antiretrovirals use. Further well-designed studies with a good sample size are needed to further explore any existing correlation between these highly malignant diseases.

Complication Profile and Outcomes Following Percutaneous Cholecystectomy Tubes for Acute Cholecystitis

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INTRODUCTION: Percutaneous cholecystectomy tubes (PCT) are commonly placed as an alternative intervention for patients with acute cholecystitis (AC) who have contraindications for cholecystectomy (CCT) due to medical comorbidities or advanced age. However, high quality data on short- and long-term complications after PCT placement for AC is limited and its use as an established treatment remains to be elucidated. In our study, we aim to assess rates of complications with emphasis on complications encountered during follow-up after initial hospitalization for PCT placement.

METHODS: We retrospectively studied a cohort of 41 patients who received PCT placement for AC. Demographic and biliary complication profile, including PCT dysfunction rates and need for re-intervention or subsequent cholecystectomy was collected.

RESULTS: We evaluated 41 patients with median age of 66.5 years (32–95). 13 patients presented acute acalculous cholecystitis and 28 patients presented with acute calculous cholecystitis. Overall complication rate was 73% with recurrent biliary symptoms (31.7%) and stent dislodgment or migration (19.5%) presenting as the most common complications. Average length of hospital stay after PTC placement was 8.43 days. Average length of time stent was in place was 54.6 days. Most common comorbidities were cardiac disease (28.6%), use of blood thinners (20.5%) and diabetes (17.8%).

CONCLUSION: Average length of hospital stay (8.4%) after PCT placement in our institution is shorter than described in the literature despite similar rates of gender and age distribution and may be attributed to differences in tube placement technique. Stent dislodgment or migration (19.5%) was one of the most common complications found at our institution. Similarly, dislodgment incidence in the literature was as high as 38%. PCT failure necessitated CCY in 19.5% of patients, sepsis occurred in 9.8% of patients, and abscess development occurred in 4.9% of patients. These complication rates suggest that although PCT is an alternative to cholecystectomy for unstable, critically ill patients or elderly patients, it may not be the best alternative. The development of lumen accessing metal axial stents for gallbladder drainage suggests a role for this approach and warrants further investigation.

S0099

Calendar Year Readmission Rates Associated With Different Etiologies of Acute Pancreatitis and Its Impact on Outcomes

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INTRODUCTION: We sought to determine the 11-month readmission rate (RR) for various etiologies of AP after an initial episode of AP, and compare the outcomes and healthcare resource utilization associated with each of them.

METHODS: Retrospective cohort using the 2016 National Readmission Database (NRD). Inclusion criteria were: principal diagnosis of AP and admission in January 2016. All readmissions to any hospital for a principal diagnosis of AP within 11 months of the index admission were recorded for each patient. Patients were divided into 5 groups based on etiology of AP and primary outcome was the 11-month RR of AP. Secondary outcomes were: number of readmissions per year in each group, index admission and calendar year mortality, treatment/managment variations in each group and healthcare resource utilization.

RESULTS: 22,472 patients hospitalized with AP in January 2016 were included. Common etiologies were biliary (16.7%), alcohol (24.1%), drug-induced (1.6%), other (54.5%) and idiopathic (3.2%). The mean age was 53 years and 41.6% were males. The 11-month RRs for biliary, alcoholic, drug-induced, other and idiopathic AP were 7.0%, 36.2%, 10.7%, 23% and 23.7%, respectively. Over 6% of patients with alcohol-induced AP and 9.3% of patients with drug-related AP had >5 readmissions in the 11-month follow-up period (Figure 1). Index admission mortality was highest in biliary pancreatitis (1%), while the calendar year mortality was highest in patients with other etiologies of AP (1.8%). Rates of percutaneous drainage were highest in patients with biliary AP (49%), while patients with idiopathic pancreatitis underwent the highest number of necrosectomies (0.9%) and had the highest need for TPN (1.5%). Patients with alcohol-induced AP had the highest rates of feeding tube placement (0.6%). Healthcare resource utilization was the highest in readmitted patients with alcohol-induced and other etiologies of AP as compared to biliary, idiopathic and drug-induced AP. Total hospital days associated with alcohol-induced AP related readmissions were 16,012 days with total healthcare costs of $114 million, while total hospital days with other AP were 25,078 days and total healthcare costs of $178 million (Figure 2).

CONCLUSION: Our study provides national data on the calendar year RR of patients with AP across different etiologies, and the impact on outcomes related to readmission. The highest RR are associated with alcohol induced AP with a significant impact on healthcare resource utilization.

Table 1. Multivariable analysis of association between HIV infection and pancreatic cancer

<table>
<thead>
<tr>
<th>Factor</th>
<th>Pancreatic cancer</th>
<th>HIV infection</th>
<th>Pancreatic cancer and HIV infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreatic cancer</td>
<td>0.65 (0.64–0.68)</td>
<td>0.64 (0.63–0.67)</td>
<td>0.64 (0.63–0.67)</td>
</tr>
<tr>
<td>Pancreatic cancer, head</td>
<td>0.64 (0.63–0.67)</td>
<td>0.64 (0.63–0.67)</td>
<td>0.64 (0.63–0.67)</td>
</tr>
<tr>
<td>Pancreatic cancer, body</td>
<td>0.65 (0.64–0.68)</td>
<td>0.64 (0.63–0.67)</td>
<td>0.64 (0.63–0.67)</td>
</tr>
<tr>
<td>Pancreatic cancer, tail</td>
<td>0.65 (0.64–0.68)</td>
<td>0.64 (0.63–0.67)</td>
<td>0.64 (0.63–0.67)</td>
</tr>
<tr>
<td>Race, smoking status, obesity</td>
<td>0.65 (0.64–0.68)</td>
<td>0.64 (0.63–0.67)</td>
<td>0.64 (0.63–0.67)</td>
</tr>
</tbody>
</table>

Figure 1. Clinical outcomes associated with various etiologies of acute pancreatitis.