Pancreatic cancer is associated with decreased survival, with a 5-year survival rate less than 40% for localized stages. Surgical resection is the mainstay of potentially curative treatment. However, not all patients with tumors eligible for surgery undergo surgical intervention. We aimed to identify the proportion of patients with pancreatic cancer who may benefit from nonsurgical, local ablative interventions.

**METHODS:** Data was extracted from the Surveillance, Epidemiology and End Results (SEER) database. Adult patients with pancreatic malignant tumors, registered in the years 2004-2017 were included. Patients were excluded if they had no microscopic confirmation, distant disease (SEER Summary stage), or unknown TNM classification or unknown tumor size.

**RESULTS:** A total of 24,594 patients met inclusion and exclusion criteria. Age bracket 50-85 constituted 86% of the cohort with 50.3% being female. The racial distribution was: 80.8% white, 10.9% black and 7.6% Asian. Tumor size was >2 cm in 14.5%, 2-4 cm in 47.7% and 2-4 cm in 37.8%. T stage was: T1 7.9%, T2 21.7%, T3 13.70, T4 16.8% (Table 1). With regards to surgical treatment, surgery was not recommended or contraindicated in 11,768 (47.6%) of the cohort, surgery was recommended but not performed in 853 (3.5%) and surgery was performed in 11,971 (48.7%). For those whom surgery was recommended but not performed, this group had a higher proportion of patients that were age >85, black race, from less populated areas (<250,000) and tumor size (2-4 cm). Reasons for not performing recommended surgery included patient’s refusal in 45.4%, patient’s death prior to surgery in 7% and unknown reasons in 47.6% (Table 2).

**CONCLUSION:** Excluding patients with metastatic disease, 51.3% of patients with pancreatic cancer are not eligible for or offered resection. Of those offered resection, 6.7% do not receive the recommended surgery. There is a large unmet need for local ablative therapy for pancreatic cancer.

**S0104**

**Diagnostic Trends and Clinical Course of Non-Gallstone Non-Alcohol-Associated Acute Pancreatitis Within a Large Health System**

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**INTRODUCTION:** Acute pancreatitis (AP) is a leading gastrointestinal cause of hospitalization in the United States. Up to two-thirds of cases are related to alcohol use (AAP) or gallstones (GAP). There is limited data on the prevalence, patient characteristics and severity of non-biliary-non-alcohol-associated AP (NNAP). We analyzed and contrasted real-world diagnostic trends and clinical outcomes of NNAP with AAP and GAP within a large multi-state health system.

**METHODS:** ICD-10 codes for AP were used to identify adult patients presenting to emergency departments (ED) within the MedStar Health system between March 2015 and June 2019. These included ED visits and inpatient admissions. Manual review yielded 2542 charts with complete clinical information, 1212 of which have AP as defined by Revised Atlanta Classification (RAC) and documented etiologies as either GAP, AAP or NNAP. Charts with unknown etiology or idiopathic were excluded. GAP, AAP and NNAP groups were then compared for the following characteristics and outcomes: patient age, lipase, presenting symptoms, imaging received, workup of etiology, treatment variables, complication rate, readmission rate and length of stay. Statistical analysis was performed using GraphPad PRISM.

**RESULTS:** A total of 1903 patients met RAC for AP and 690 patients were excluded due to having unknown or idiopathic etiology in documentation. The prevalence of NNAP was 10.7% and these patients were more likely to have elevated lipase (OR 1.65, 95% CI 1.11, 2.46, P = 0.007) compared to patients with GAP and AAP. Incidence of workup was higher in the NNAP group (OR 4.81, 95% CI 2.01, 11.12, P = 0.007) compared to GAP and AAP. NNAP group had a higher proportion of patients that were age >85, black race, from less populated areas (<250,000) and tumor size (2-4 cm). Reasons for not performing recommended surgery included patient’s refusal in 45.4%, patient’s death prior to surgery in 7% and unknown reasons in 47.6% (Table 2).

**CONCLUSION:** Excluding patients with metastatic disease, 51.3% of patients with pancreatic cancer are not eligible for or offered resection. Of those offered resection, 6.7% do not receive the recommended surgery. There is a large unmet need for local ablative therapy for pancreatic cancer.

**S0106**

**Etiologies of patients with acute pancreatitis other than gallstone or alcohol.**

INTRODUCTION: The American Journal of GASTROENTEROLOGY
CONCLUSION: As expected, patients with AP requiring ICU level care had higher incidence of comorbidities and experienced longer hospital stays. Specifically, patients who have lung disease, CAD, HTN, or cirrhosis may benefit from closer monitoring. Our study provides valuable insights into patient and treatment characteristics that may predispose to ICU admissions in AP.

SO106

Imaging Resource Utilization in the Surveillance of Presumed Branch duct Intraductal Papillary Mucinous Neoplasm (BD-IPMN)

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INTRODUCTION: Presumed mucinous cystic lesions are at increased (albeit low) risk of malignant transformation and require regular imaging for ongoing surveillance. A cost-effective evaluation of imaging resource utilization (IRU) is understudied due to a paucity of actual clinical utilization data and lack of consensus among current guidelines. We assessed the value proposition of IRU in surveillance of BD-IPMN, by defining populations utilizing high volumes of imaging, and identifying the predictors of high IRU.

METHODS: This is a single-center cross-sectional study, of patients with presumed BD-IPMN under active surveillance as of January 2018. Patients were identified from a prospectively maintained pancreatic cyst neoplasm (PCN) database. Presumed diagnosis of mucinous cysts with identification of worrisome features (WF) and high-risk stigmata (HRS), was made based on the accepted criteria from the literature. IRU was calculated based on both noninvasive (CT/MRI) and minimally invasive (EUS) imaging used per month during surveillance. For analysis, the “High Resource Utilization” (HRU) group is defined as the top 10% of the population consuming higher imaging resources and compared them with rest of the surveillance population: “Low Resource Utilization” (LRU) group. The clinical variables were compared using chi-square analysis and student’s t test between two groups.

RESULTS: 409 patients with presumed BD-IPMNs were followed for an average of 41.60 ± 32.24 months. By definition, the rate of surveillance imaging utilization per month in HRU group was higher, 0.74 ± 0.42 vs 0.16 ± 0.09 (P < 0.001). Similarly, the rate of non-invasive imaging and EUS utilization was also higher in HRU group. The HRU group have a higher initial cyst size (14.31 vs 12.90 mm) (P < 0.001), higher proportion of cysts with WF (17.5% vs 13.8%2) (P < 0.001), compared with LRU group: Cyst growth rate per year (30.00% vs 4.88% (P < 0.001) and per two years (50.00% vs 13.8%) (P < 0.001) displayed higher proportions of fast-growing cysts (>5 mm threshold) in the HRU group compared with LRU group.

CONCLUSION: Higher IRU was found in a subset of presumed BD-IPMN population undergoing active surveillance using actual prospective clinical data. Predictors of this included larger initial cyst size, rapid cyst growth rate over one and two years, and the presence of WF and HRS. Further refinement of imaging guidelines is needed for accurate long-term PCN surveillance balanced by cost-effective IRU.