INTRODUCTION: Endoscopic retrograde cholangiopancreatography (ERCP) is an endoscopic procedure performed for multiple diagnostic and therapeutic indications. It carries benefits and risks like all other interventions. We focused on radiation exposure to patients and staff. In the literature review, we found that radiation dose is lower when radiation administration is physician-controlled, and as the physician becomes more experienced, they utilize less radiation. The aim was to compare different operation techniques of radiation administration during ERCP.

METHODS: This was a retrospective study of all 437 ERCP procedures performed at a tertiary care hospital between April 2015 and April 2017. Data were collected from the electronic hospital system and included demographics, procedure indication, fluoroscopy time (FT), dose area product (DAP), degree of difficulty as per American Society of Gastrointestinal Endoscopy (ASGE) recommendations. Median and mean FT and DAP between endoscopist-controlled (EC) compared to technician-controlled (TC).

RESULTS: Of the 437 cases analyzed 45.5% males, and the mean age was 56.7. EC was 187 cases, representing 42.79%. The mean fluoroscopy time (FT) was 2.107 ± 2.0 minutes. The mean dose-area product (DAP) was 15225.38 ± 9497.6 cm2 for all procedures. The degree of ERCP difficulty was graded from 1-4 as per ASGE. Level I TC procedures had a mean FT of 1.600 ± 745.80 minutes and DAP of 12954.36 ± 5856.5 cm2. For level IV procedures, the mean FT was 4.890 ± 12644.72 minutes and DAP was 15227.37 ± 12644.72 cm2.

CONCLUSION: This study did not show a significant difference in radiation dose between EC and TC except in ASGE level IV, where a significant increase was noticed in the EC group. The results of multiple other fluoroscopic studies in urology and cardiology showed that when the procedure is physician-controlled, radiation administered is similar or lower than TC. This difference in comparison to the other studies could be attributed to the endoscopist’s attention divided into multiple fronts, including doing the procedure that predisposes them to push on the pedal for longer than intended while manipulating the scope and leading the team. Although these results are inconclusive, it does shed light on the importance of further studies on radiation administration techniques for patients and staff safety.

INTRODUCTION: Chronic opioid use is prevalent in patients with gastroparesis and has been associated with more severe gastrointestinal symptoms and increased healthcare utilization. GPOEM has gained recognition as an effective endoscopic therapy for treatment of refractory gastroparesis. Currently there is limited knowledge of the effect of opiate use in patients undergoing GPOEM.

METHODS: We performed a single-center retrospective study of patients who underwent GPOEM for refractory gastroparesis. Patients were stratified into two groups: 1) patients on chronic opiates prior to and after GPOEM and 2) patients who were not on chronic opiates prior to or after GPOEM. Primary outcomes included gastric emptying study results pre- and post-GPOEM and symptom response pre- and post-GPOEM as measured by the Gastroparesis Cardinal Symptom Index (GCSI), a validated nine-item questionnaire with 3 subscores that rate symptom severity from absent (0) to severe (5). Univariate statistical analysis was performed using t-test (SAS, version 9.4).

RESULTS: 22 patients underwent GPOEM from 2017 to 2019. Nine (41%) patients were prescribed chronic opiates both prior to and after GPOEM, while 13 (59%) patients did not have chronic opiate prescriptions before and after GPOEM. The etiology of gastroparesis was pre- dominated by post-surgical, accounting for 7 (78%) patients on opiates and 8 (62%) patients without opiates. Mean follow-up time for all patients after GPOEM was 8.21 ± 4.6 months. Opiate users had higher baseline and post-GPOEM four-hour residuals on GES compared to patients without opiate use (baseline: 59.3% vs 43%, P = 0.18; post-GPOEM: 40.3% vs 19.7%, P = 0.27). Mean total GCSI prior to GPOEM was not significantly different between opiate and non-opiate users (3.24 vs 3.01, P = 0.63). Non-opiate users had significantly lower mean total GCSI after GPOEM compared to patients on opiates (1.32 vs 2.32, P < 0.05), as well as significantly greater overall improvement in GCSI (56% vs 17%, P < 0.05).

CONCLUSION: Non-opioid users appear to respond more favorably to GPOEM as characterized by significantly greater improvements in GCSI scores, and significantly lower overall GCSI scores following this intervention. Multidisciplinary approaches incorporating opioid weaning protocols prior to GPOEM may improve symptom-based outcomes subsequent to this procedure.

Effect of Opiate Usage on Patient Outcomes After Gastric Per-Oral Endoscopic Pyloromyotomy (GPOEM) for Refractory Gastroparesis

Gregory Dean, MD1, Kevin Liu, MD2, Thomas Erke, MD2, Darren Brenner, MD, FACC2, Peter Kahrius, MD2, John E. Pandolfino, MD, FACC1, Aasif Aadam, MD2.
1Northwestern University Feinberg School of Medicine, Chicago, IL; 2Northwestern University, Chicago, IL.

Introduction: Gastric emptying after GPOEM is a validated nine-item questionnaire with three subscores that rate symptom severity from absent (0) to severe (5). Univariate statistical analysis was performed using t-test (SAS, version 9.4).

Results: Twenty-two patients underwent GPOEM from 2017 to 2019. Nine (41%) patients were prescribed chronic opiates both prior to and after GPOEM, while 13 (59%) patients did not have chronic opiate prescriptions before and after GPOEM. The etiology of gastroparesis was predominantly post-surgical, accounting for 7 (78%) patients on opiates and 8 (62%) patients without opiates. Mean follow-up time for all patients after GPOEM was 8.21 ± 4.6 months. Opiate users had higher baseline and post-GPOEM four-hour residuals on GES compared to patients without opiates (baseline: 59.3% vs 43%, P = 0.18; post-GPOEM: 40.3% vs 19.7%, P = 0.27). Mean total GCSI prior to GPOEM was not significantly different between opiate and non-opiate users (3.24 vs 3.01, P = 0.63). Non-opiate users had significantly lower mean total GCSI after GPOEM compared to patients on opiates (1.32 vs 2.32, P < 0.05), as well as significantly greater overall improvement in GCSI (56% vs 17%, P < 0.05).

Conclusion: Non-opioid users appear to respond more favorably to GPOEM as characterized by significantly greater improvements in GCSI scores, and significantly lower overall GCSI scores following this intervention. Multidisciplinary approaches incorporating opioid weaning protocols prior to GPOEM may improve symptom-based outcomes subsequent to this procedure.
**Novel Axially Paralleled Endoscopic Submucosal Dissection Knife vs Insulated Tip Endoscopic Submucosal Dissection Knife: Outcomes of a Randomized ex-vivo Pilot Study**

Ahmad Naidad Bazargani, MD,1 Pokharel Itipravati, MD, MPH,2 Phillip Ge, MD,3 Jingbo Zhang, MD,1 Hiroshi Yoshiya, MD, PhD,2 Christopher C. Thompson, MD, MS,2 1Brigham & Women’s Hospital, Somerville, MA; 2Brigham & Women’s Hospital, Boston, MA; 3University of Texas MD Anderson Cancer Center, Houston, TX; China Medical University, Beijing, China.

**INTRODUCTION:** Endoscopic Submucosal Dissection (ESD) is utilized for the treatment of large gastrointestinal tract lesions or lesions not amenable to standard endoscopic mucosal resection. Insulated tip (IT-ESD) knife is a commonly used knife for ESD. A recent axially paralleled ESD (AP-ESD) knife is claimed to have improved cutting ability, higher resection rate, lower perforation rate, and a lower learning curve with this new device and extensive familiarity with conventional knives.

**METHODS:** A total of 18 participants performed 2 tissue resections (1 AP-ESD and 1 IT-ESD), for a total of 36 procedures. Complete on-site cytopathologic evaluation was performed in all 33 procedures (resection rate 91.6%). No differences were observed in complete resection or perforation rate between IT-ESD and AP-ESD (88.2% vs 94.4%, P = 0.51 and 11.8% vs 11.1%, P = 0.95, respectively). Participants had a longer time with AP-ESD (1045 ± 779 vs 783 ± 532 seconds, P = 0.04) however there was no difference in time demand using total NASA TLX (33 ± 11 vs 39 ± 9, P = 0.07). While experts (N = 9) had longer time with AP-ESD (985 ± 649 vs 595 ± 383, P = 0.05), there was no difference in resection rate, perforation rate or NASA TLX demand. On the other hand, Novices (N = 9) showed no difference in resection rate, perforation rate or procedure time (however did have higher demand with AP-ESD (45 ± 9 vs 37 ± 11, P = 0.05).

**CONCLUSION:** AP-ESD knife yielded similar rates of resection and perforation compared to a standard IT-ESD knife. Experts endoscopists required more time for dissection, likely due to an undefined learning curve with this new device and extensive familiarity with conventional knives.

**S05954**

**Compliance With ASGE Quality Indicators for Endoscopic Ultrasound Reports in the Evaluation of Pancreatic Cancer: Comparison of Community and Academic Practices**

Michael Weaver, MD,1 Stephen Hausk, MD, MPH,2 Dayna Early, MD,3 Daniel Mullady, MD,1 Gabriel Lang, MD,1 Kevin Das, MD,1 Natália Covore, MD,2 William Hawkins, MD,1 Ryan Fields, MD,1 Marwin Petty, BS, MBA,4 Greg Williams, MD, BA,5 Rajeev Ranogopal, MD,1 Ayman Abu-Nah-ab, MD,1 Vladimir Kuzhir, MD,1 1Barnes-Jewish Hospital at Washington University in Saint Louis, St. Louis, MO; 2Washington University University School of Medicine, St. Louis, MO; 3Washington University School of Medicine, St. Louis, MO.

**INTRODUCTION:** The American Society for Gastrointestinal Endoscopy (ASGE) has put forth a list of quality indicators (QI) for EUS which evaluate key steps that provide endoscopists' standards to provide high quality care. Endoscopist compliance with the ASGE QI has not been well studied in patients who have undergone EUS and subsequent resection for pancreatic cancer. The goal of this study is to evaluate the quality of EUS performed for pancreatic cancer diagnosis and staging according to ASGE guidelines.

**METHODS:** Consecutive patients who had EUS for suspected pancreatic malignancy and who had subsequently undergone surgical resection at a single tertiary care center between 2013 and 2019 were identified by searching an IRB approved surgical database of patients with resected pancreatic cancer. Patients with incomplete documentation were excluded. Patient demographics, pancreatic lesion characteristics, surgical pathology and operative reports, as well as EUS report data were recorded. Analysis of EUS performed at a single academic medical center (AMC) and referring community hospitals (OHS) was performed to compare adherence to ASGE QI.

**RESULTS:** 279 patients underwent surgical resection for pancreatic cancer between 2013 and 2019 and had an EUS report available for review. 207 EUS were performed at AMC and 72 were performed at OHS. Significant differences between AMC and OSH EUS reports were noted including total number of ASGE QI (6.7 ± 0.1 vs 5.6 ± 0.2, P = 0.015), vascular involvement documentation (88.9% vs 52.8%, P = 0.015), vascular involvement documentation (78.5% vs 65.3%, P = 0.039), lymph node involvement documentation (89.3% vs 77.8%, P = 0.027), and TMM classification (56.5% vs 19.4%, P < 0.001) were significantly higher in the AMC EUS reports. EUS-FNA/B revealed malignancy in 88.9% cases at the AMC and 76.4% at OSH.

**CONCLUSION:** In our cohort of patients with resected pancreatic cancer who had previously undergone EUS, the quality of EUS reports from an AMC were superior to OSH EUS reports based on ASGE QI for EUS. Furthermore, there was a statistically significant increase in the