during a 30-day period (exact-matched [EM] hazard ratio [HR] 1.34, 95% CI: 1.19 – 1.52, p<0.001; EM-Odds Ratio [OR] 1.51, 95% CI: 1.27 – 1.79, p<0.001). Non-Matched analyses are shown in Table 2. The majority of primary discharge diagnoses for re-admissions was related to pancreatic disorders (44%), especially AP. The aggregate costs of re-admissions with OAD in 2014 were $12.1 million USD (n=1,159). **Conclusion**: It is evident that OAD contributes significantly to the rate of re-admissions in patients admitted with Acute-On-Chronic Pancreatitis, independently contributing to increased health-care utilization. Further measures against OADs in these patients, such as alternative pain control therapies, may potentially alleviate such increase in health-care use.

Variable	No OAD Disorder [% or mean ± SD] N=240,990	OAD Disorder [% or mean ± SD] N=4,823	Overall [% or mean ± SD] N=245, 813	p-value
30-day Readmission (Any-Cause)	15.5% n=37,353	24.4% n=1,177	15.7% n=38,531	<0.001
30-day Readmission for Acute Pancreatitis	6.5% n=15,593	10.3% n=497	6.5% n=16,090	<0.001
Mean Age (years) †	52.2 ± 0.1	44.7 ± 0.3	52.0 ± 0.1	<0.001
Female Gender †	48% n=115,767	46.2% n=2,230	48% n=117,997	0.191
Charlson Comorbidity Index †	0.95 ± 0.001	1.13 ± 0.040	0.95 ± 0.001	<0.001
Median Length of Stay in days (IQR) †	3 (2-5)	4 (2-6)	3 (2-5)	<0.001
Hospitalization Costs ($US)	9,944 ± 119	10,657 ± 360	9,958 ± 119	0.039
Discharge to ACF/SNF/LTACH †	10.7% n=25,692	9.7% n=467	10.6% n=26,158	0.179
Acute Kidney Injury †	9.5% n=22,800	9.1% n=439	9.5% n=23,239	0.639
Respiratory Failure †	4.6% n=11,186	4.8% n=234	4.6% n=11,419	0.715
Admitted in ICU †	1% n=2,458	1.3% n=65	1% n=2,523	0.152
Cholecystectomy †	11.6% n=28,029	2.5% n=121	11.5% n=28,149	<0.001
Pancreatectomy †	0.7% n=1,679	0.6% n=31	0.7% n=1,710	0.824
Gallstone Disease †	21.2% n=51,076	7.1% n=344	20.9% n=51,420	<0.001
History of Bariatric Surgery †	1.6% n=3,860	2.1% n=103	1.6% n=3,963	0.059
Alcoholism †	41.8% n=100,770	74% n=3,569	42.4% n=104,339	<0.001
Morbid Obesity †	6.9% n=16,689	4.3% n=208	6.9% n=16,897	<0.001
Psychiatric Disease or Depression †	19% n=45,844	37.8% n=1,825	19.4% n=47,669	<0.001
Insurance †				
Medicare	32% n=77,097	25.7% n=1,236	31.9% n=78,333	
Private Insurance	32.3% n=77,720	17.2% n=826	32% n=78,546	<0.001
Medicaid/Self-Pay/Charity Care/Other	35.6% n=85,747	57.2% n=2,753	36.1% n=88,500	
Bed Size †				
Small	19.7% n=47,492	18% n=867	19.7% n=48,360	
Medium	29% n=69,851	29.5% n=1,421	29% n=71,272	0.496
Large	51.3% n=123,647	52.6% n=2,535	51.3% n=126,181	
Hospital Teaching Status †				
Metropolitan non-teaching	30.6% n=73,820	29.2% n=1,408	30.6% n=75,228	
Metropolitan teaching	56.5% n=136,111	62.5% n=3,016	56.6% n=139,127	<0.001
Non-metropolitan	12.9% n=31,059	8.3% n=399	12.8% n=31,458	
Hospital Location †				
Large metropolitan (≥ 1 million residents)	51.1% n=123,250	58.7% n=2,830	51.3% n=126,080	
Small metropolitan (<1 million residents)	36% n=86,681	33% n=1,594	35.9% n=88,275	<0.001
Micropolitan areas	8.9% n=21,329	5.8% n=280	8.8% n=21,610	
Rural	4% n=9,730	2.5% n=118	4% n=9,848	
Income Class				
1st Quartile	30.5% n=72,360	34.5% n=1,642	30.6% n=74,003	
2nd Quartile	28.1% n=66,705	26.6% n=1,264	28.1% n=67,968	0.029
3rd Quartile	22.8% n=54,104	20.9% n=995	22.8% n=55,100	
4th Quartile	18.5% n=43,888	18% n=855	18.5% n=44,743	

Bivariate analysis was done by chi-square test or t-test (with as-needed log-transformation), for categorical and continuous variables respectively.
IQR, Interquartile Range; ICU, Intensive Care Unit; ACF/SNF/LTACH, Acute Care Facility/Skilled Nursing Facility/Long-Term Acute Care Facility.
† Confounder used in matching.

Table 1. Baseline Characteristics

Variable	Odds Ratio (95% CI)	p-value	Hazard Ratio (95% CI)	p-value	Time Ratio (95% CI)	p-value
OAD	1.34 (1.19 – 1.51)	<0.001	1.30 (1.17 - 1.43)	<0.001	0.77 (0.69 - 0.85)	<0.001
OAD (exact-matched)	1.51 (1.27 – 1.79)	<0.001	1.34 (1.19 – 1.52)	<0.001	0.74 (0.65 – 0.84)	<0.001
Age (per year-increase)	0.990 (0.988 – 0.992)	<0.001	0.991 (0.989 - 0.992)	<0.001	1.100 (1.083 - 1.117)	<0.001
Charlson Comorbidity Index (CCI)	1.12 (1.10 – 1.13)	<0.001	1.1 (1.09 - 1.11)	<0.001	0.91 (0.90 - 0.92)	<0.001
Length of stay (per day-increase)	1.020 (1.017 – 1.024)	<0.001	1.013 (1.011 - 1.015)	<0.001	0.987 (0.985 - 0.989)	<0.001
Alcoholism	1.049 (1.004 – 1.096)	0.033	Stratified		0.96 (0.92 – 1.00)	0.041
Acute Kidney Injury	1.15 (1.08 – 1.23)	<0.001	1.15 (1.08 - 1.22)	<0.001	0.87 (0.82 - 0.92)	<0.001
Morbid Obesity	0.86 (0.79 – 0.94)	0.001	0.88 (0.81 - 0.95)	0.001	1.14 (1.06 - 1.24)	0.001
Psychiatric Disease or Depression	1.46 (1.39 – 1.53)	<0.001	1.39 (1.33 - 1.46)	<0.001	0.71 (0.68 - 0.75)	<0.001
Cholecystectomy	0.46 (0.42 – 0.49)	<0.001	0.48 (0.44 - 0.53)	<0.001	2.09 (1.92 - 2.28)	<0.001
Pancreatectomy	1.57 (1.30 – 1.91)	<0.001	1.52 (1.31 - 1.77)	<0.001	0.65 (0.55 - 0.76)	<0.001
History of Bariatric Surgery	1.17 (1.01 – 1.36)	0.04	1.14 (1 - 1.3)	0.056	0.88 (0.77 - 1.00)	0.058

All Analyses were adjusted for disposition and insurance status. Patients who left "Against Medical Advice" were excluded.
Exact-matched analyses included Age, CCI and Length of Stay in the robust regression (post-matching) model.
NOTE: Hazard ratio (Cox Regression Analysis) was stratified by alcoholism status and Time Ratio (Accelerated Failure Time Analysis) was stratified by the variables of gallstone disease and alcoholism.

Table 2. Predictors of 30-day Re-Admisisons

Su1423

GASTROINTESTINAL FAILURE IS A PREDICTOR OF POOR OUTCOME IN PATIENTS WITH ACUTE PANCREATITIS

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Objectives: Although gastrointestinal dysfunction is common in patients with acute pancreatitis, it has not been extensively studied. Our primary objective was to study the effect of gastrointestinal failure (GIF) in patients in acute pancreatitis, and its effect on outcome. **Methods:** Patients with acute pancreatitis more than 18 years of age admitted in our unit between July 2016 and December 2017 were prospectively studied. Gastrointestinal dysfunction and intra abdominal pressures (IAP) were measured daily till their normalisation. Baseline parameters and various severity scores were recorded at admission. Gastrointestinal failure score was calculated daily till resolution or death. GIF was calculated as proposed by Reintam and colleagues and included feeding intolerance and intra-abdominal pressure as its parameters. **Results:** Of the 70 patients included in the study, the mean age was 41.6 ± 16.26 years, with 70% being males. Alcohol was the most common etiology (41.4%). 72.9% patients had severe disease and mean modified CT severity index (MCTSI) was 8.32 ± 2.07. Among the organ failure cases, 7.2% had transient organ failure, and 92.8% had persistent organ failure. Acute lung injury was the most common organ failure present in 78.6% cases. Twenty patients (28.6%) succumbed to their illness. GIF was present in 48.4% cases, intra-abdominal hypertension (IAH) in 59.3% patients, and feeding intolerance in 57.8% patients. The mean duration of GIF was 3.3 ± 4.93 days. Presence of GIF and its duration were significantly associated with mortality (p value <0.05). Also, the mean IAP, GIF score, and APACHE II, CTSI, MCTSI, Modified Marshal score, systemic inflammatory response syndrome (SIRS) and BISAP scores at presentation were significantly higher among the patients who succumbed. Other parameters significantly associated with mortality were the duration of ICU stay, and presence of respiratory, renal and circulatory failure. On multivariate analysis, presence of GIF and duration of ICU stay were found to be independent predictors of mortality (Table 1). **Conclusion:** Gastrointestinal failure is an important aspect in patients with acute pancreatitis, and it is an independent predictor of outcome. Incorporation of gastrointestinal failure scores in dynamic assessment of patients with acute pancreatitis could help us in stratifying severity of patients, prognosticating patients, and predicting outcome.

Table 1: Multivariate Regression analysis for predictors of mortality

Parameters	B	S.E.	P value	Odds Ratio	95% C.I. for OR	
					Lower	Upper
Duration of ICU Stay	.079	.032	**.015**	**1.082**	1.015	1.153
GIF(Presence)	2.361	.858	**.006**	**10.603**	1.971	57.036

Su1424

IS EARLY CT OVERUTILIZED IN MANAGEMENT OF FIRST EPISODE ACUTE PANCREATITIS AND DOES IT IMPACT PATIENT OUTCOMES?

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Background: The utilization of Computed Tomography (CT) in the management of acute pancreatitis is important in the diagnosis of pancreatic necrosis. Based on IAP/APA and ACG guidelines, the diagnosis of acute pancreatitis requires 2 of 3 criteria: epigastric pain, lipase 3x ULN, and CT findings. CT is not required if the other two criteria are met. Data regarding the utilization of early CT < 24 hours of admission is limited. Our goal was to evaluate early CT utilization in patients presenting with first episode of acute pancreatitis. **Methods:** We performed a retrospective chart review on patients admitted to 3 facilities with new diagnosis acute pancreatitis between 2016-2018. Inclusion criteria were all patients aged