

FINAL ID: S18

TITLE: Impact of Socioeconomic Factors in Time to Treatment of Patients with Squamous Cell Anal Cancer

ABSTRACT BODY:

Purpose/Background: Disparities in socioeconomic conditions have implications in the access to health care and may affect the treatment decision-making as well as survival. Squamous cell anal cancer (SCCA) accounts for 2.7% of gastrointestinal cancers and the incidence is rising. Multimodal chemoradiotherapy is the mainstay of treatment, and surgery is indicated for those who have persistent or recurrent disease. In this study we investigated the impact of socioeconomic factors on time to treatment and outcomes of SCCA.

Methods/Interventions: We identified patients treated for stage I-IV SCCA 2004-2016 using the National Cancer Database. Socioeconomic factors, including insurance, median household income, and percentage of no high school degree (HSD) in the zip code of residence, were included. The associations between these factors and time from diagnosis to treatment, diagnosis to radiation, and diagnosis to systemic therapy were analyzed. Further, we divided patients into two groups: those who received treatment within 60 days vs after 60 days and compared the survival of the patients using Kaplan-Meier survival analysis.

Results/Outcomes: A total of 30,106 patients who underwent treatment for SCCA were identified. Median age was 59 (range, 20-90) years and 30.9 % were male. The patient population was comprised of 80 % Non-Hispanic White, 10% Black, and 4% Hispanic. 43% patients had private insurance, 10% had Medicaid, 38% had Medicare, 2% had other government insurance, and 5% had no insurance.

The median days from diagnosis to start of treatment was 33 days, radiation was 35 days, and systemic therapy was 37 days. Patients in lower income quartiles had longer wait to start overall treatment ($p < 0.001$), radiation ($p < 0.001$), and systemic therapy ($p < 0.001$) compared to higher income quartiles. Patients from zip codes with higher percentage of no HSD had longer wait to overall treatment ($p = 0.000$), radiation ($p = 0.000$), and systemic therapy ($p = 0.000$).

Patients with 'other government insurance' followed by Medicaid insurance had longer wait to treatment ($p = 0.000$), radiation ($p = 0.000$), and systemic therapy ($p = 0.000$) compared to other primary payer status.

Patients who started treatment more than 60 days after the diagnosis were likely from the communities with low median income ($p < 0.001$) and low education level ($p < 0.001$), and enrolled in Medicaid ($p < 0.001$). There was no difference in 30-day mortality ($p = 0.832$) and 90-day mortality ($p = 0.231$) between the groups. However, Kaplan-Meier survival analysis showed that the group receiving treatment after 60 days had poorer survival compared to those received within 60 days (32.6 vs. 36.7 months; $p < 0.001$).

Conclusions/Discussion: Patients from communities with lower median income and level of education, and enrolled in Medicare managed care had longer wait to treatment, which was associated with poorer overall survival. These results warrant further analysis and measures to address this disparity.

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FINAL ID: S19

TITLE: Predictive Factors for Failure of Same-Day Discharge Following Minimally Invasive Colectomy and Stoma Reversal

ABSTRACT BODY:

Purpose/Background: Same-day discharge (SDD) following minimally invasive (MIS) colectomy may further improve efficiency of enhanced recovery pathways. We have previously demonstrated the feasibility of SDD in select patients but there is still a failure rate. Identification of patients at risk of SDD failure may further improve perioperative planning. We sought to describe our experience with SDD for MIS colectomy and identify predictors for SDD failure.

Methods/Interventions: Adult patients undergoing elective MIS colectomy or ostomy reversal at a tertiary colorectal centre from 02/2020–09/2022 were considered for SDD with remote post-discharge follow-up if they had few comorbidities, lived near the hospital, had adequate home support, and owned a mobile device. Patients were discharged on postoperative day (POD) 0 if the following criteria were met: adequate analgesia with oral medication, tolerated liquids without nausea, independent ambulation, urination, and no complications. Successful SDD was defined as discharge on POD0 without unplanned visits in the first 72hrs. Data was collected in a prospective manner comparing the SDD patients to those who failed SDD.

Results/Outcomes: Of the 361 patients undergoing MIS colectomy, a total of 172 patients were consented and managed with SDD (mean age 58.1yr(SD15.5), 50% male, body mass index 26.7kg/m^2 (SD5.7), mean Charlson Comorbidity Index 2.9(SD2.0), 55% malignancy). The most common procedures were right colectomy(33%), stoma closure(28%), left colectomy(24%), and low anterior resection(15%). The mean operative time was 132 min(SD65) and time spent in recovery 343 min(SD329). The overall SDD failure rate was 23%(39/172), with 15% not discharged on POD0 and 8% requiring an unplanned visit within 72hours. The reasons for SDD failure are shown in Table 1. Median LOS was 1d[IQR1-3] for patients that failed SDD. Total 30-day complications occurred in 24%(41/172), with 20%(34/172) requiring emergency room visit and 11%(19/172) readmission. The only significant predictive factors for SDD failure was prolonged time in the recovery room (median 335min[IQR200-600] vs. 260min[IQR190-335], $p<0.001$) and increased in-hospital postoperative opioid requirements(median 29 morphine mg equivalents [IQR8-45]vs. 15[IQR 8-31]).

Conclusions/Discussion: SDD is feasible in select patients undergoing MIS colectomy and stoma closure with only a 23% rate of failure, and few overall complications and readmission. Patients who failed SDD stayed longer in the recovery room and used more opioids. These data may be used to further enhance the perioperative management and reduce resource utilization for patients undergoing MIS colectomy and stoma closure.

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Table 1 – Reasons for SDD failure

Reasons for failure to discharge on POD0	n=26
Patient/family refusal	6
Inadequate pain control	4
Persistent nausea	1
Intraoperative/early postoperative complications	15
Anastomotic bleeding	4
Cardiac monitoring/complications	3
Conversion to open surgery	2
Genitourinary complications	2
Rectus sheath hematoma	1
Unplanned stoma	1
Prolonged operating time	1
Spinal anesthesia complications	1
Unplanned visits within first 72 hours	n=14
Anastomotic bleeding	4
Urinary retention	3
Gastrointestinal dysfunction	3
Wound dehiscence	1
Inadequate pain control	1
Anastomotic leak	1
Fever without etiology	1

Table 1 - Reasons for SDD failure

IMAGE CAPTION: Table 1 - Reasons for SDD failure

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FINAL ID: S20

TITLE: Loop Ileostomy Closure as a 23-hour Stay Procedure: A Randomized Controlled Trial

ABSTRACT BODY:

Purpose/Background: Loop ileostomy closure is a common procedure in colorectal surgery. Often seen as a simple and safe operation associated with low complication rates, it still leads to lengthy hospitalization. Postoperative ileus is the most frequent complication implying that reduced rates could lead to shorter length of stay and even ambulatory surgery. Up until this clinical trial, the standard of care at our tertiary care center has been to discharge patients after an ileostomy closure once they had return of bowel function, representing 645 days of hospitalization each year, with a median length of stay of 5 days. The purpose of this study was to assess the safety and feasibility of ileostomy closure performed in a 23-hour hospitalization setting using a standardized enhanced recovery pathway.

Methods/Interventions: This randomized controlled trial included healthy adults (ASA I-II) undergoing elective ileostomy closure. All patients were enrolled in a standardized enhanced recovery pathway specifically designed for ileostomy closure, including daily irrigation of the efferent limb with an enteral nutritional formula for 7 days prior to surgery. Once surgery was completed, patients were randomized to either conventional hospitalization (CH) or a 23-hour stay (23HS). Primary outcome was total length of stay (initial hospitalization and additional days associated with readmission) and secondary outcomes were 30-day rates of readmission, postoperative ileus, surgical site infection and general postoperative morbidity and mortality.

Results/Outcomes: Due to COVID-19, access to surgical beds was greatly limited, leading to a shift toward ambulatory surgery for ileostomy closure, and so the study was terminated early. A total of 47 patients were ultimately randomized; 23 in the CH arm and 24 in the 23HS arm. Patients in the 23HS arm had a shorter median length of stay (1 day vs. 2 days, $p=0.015$) and no significant difference in readmission rates (4% vs. 13%, $p=0.348$), postoperative ileus (none in both arms), surgical site infection (0 vs. 4%, $p=0.489$), postoperative morbidity rates (17% vs. 22%, $p=0.724$) and mortality rate (none in both arms).

Conclusions/Discussion: In conclusion, this study suggests that doing loop ileostomy closures as 23-hour stay procedures in a standardized enhanced recovery pathway is feasible and safe. These results also propose that ileus rate following ileostomy closure could potentially be reduced by a preoperative intestinal stimulation with an enteral nutritional formula through the efferent limb.

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FINAL ID: S21

TITLE: Exercise Frequency and Physician Burnout Among Colorectal Surgeons in the United States: Should We be Worried?

ABSTRACT BODY:

Purpose/Background: Burnout and low quality of life are common among surgeons in the United States. Self-care habits and exercise can increase quality of life but have not been evaluated among colorectal surgeons. The primary aim was to evaluate physical activity among colorectal surgeons in the US and discern a correlation between exercise and burnout. The secondary aim was to identify the most common symptoms related to burnout.

Methods/Interventions: A twelve-question, voluntary, anonymous survey approved by the American Society of Colon and Rectal Surgeons (ASCRS) Executive Council was sent to all members between June 1st and July 30th, 2022. Questions were derived from the Mayo Clinic Physician Well-Being Index and questions related to physical activity were added. Exercise was defined as 30 min or more of any dedicated physical activity. Burnout questions were asked pertaining to the last 6 months. Responses were analyzed via the Qualtrics XM survey platform. Exclusion criteria included medical students, surgical residents, international ASCRS members and incomplete responses.

Results/Outcomes: A total of 288 responses were recorded, 80 of which were excluded. The surgeons had a median of 16.2 [range 0–50] years in practice. Of these, 29 (13.9%) exercise every day, 90 (43.3%) 4-6 days a week, 61 (29.3%) 1-3 days a week, 7 (3.4%) 1-2 a month, and 21 (10.1%) stated it depended on their schedule. One hundred fifty respondents (72.1%) exercise after work and 98 (47.1%) exercise before work. Ten respondents (4.8%) exercise at work. The most common type of exercise was strength training (111/208, 53.4%), followed by running (90/208, 43.3%) and walking (75/208, 36.1%). Exercise mitigated stress in 186 (89.4%) members.

In the last 6 months, 161 (77.4%) members sometimes or often felt burnout from work, 140 (67.3%) worried that their work is hardening them emotionally, 109 (52.7%) have felt down, depressed, or hopeless, 117 (56.3%) felt that things are piling up so high they cannot overcome them, and 144 (69.2%) have been anxious, depressed, or irritable. Respondents who rarely or never exercise were more likely to report feeling down, depressed, or hopeless ($p = 0.058$) and had significantly greater rates of work overload ($p = 0.003$).

Among the members who experience significant work overload, 118 (56.7%, $p < 0.001$) also feel burnout from work, 90 (43.3%, $p < 0.001$) feel down, depressed, and hopeless, and 107 (51.4%, $p < 0.001$) feel that work is hardening them emotionally.

Conclusions/Discussion: Burnout and depressive symptoms are present among colorectal surgeons in the United States. The most commonly reported concern is work overload causing burnout symptoms. Physical activity mitigates stress among exercising colorectal surgeons, but there should be other systemic measures to improve surgeons' well-being. Further analysis and initiatives at local, regional, and national levels should be performed and implemented.

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FINAL ID: S22

TITLE: Dexamethasone-supplemented TAP blocks may reduce opioid requirements after colorectal surgery: Preliminary analysis from a randomized controlled trial

ABSTRACT BODY:

Purpose/Background: The transversus abdominis plane (TAP) block is a peripheral nerve block that reduces postoperative opioid requirements. The use of dexamethasone in conjunction with peripheral nerve blocks has been proven to be an effective adjunct, however, its use in the context of TAP blocks is undetermined. In this multicenter randomized trial, we assessed pain control and nausea in the first 48 hours post-operatively after minimally invasive colorectal surgery in patients who received laparoscopically placed TAP blocks with and without perineural dexamethasone.

Methods/Interventions: This study is powered to include 60 patients from two academic hospitals that perform colorectal surgery in Saskatoon and Vancouver. Twenty-four patients undergoing laparoscopic colorectal surgery were included in this analysis. Patients were allocated into 2 groups. Group 1 (TAP) received bilateral TAP blocks using 0.25% bupivacaine with epinephrine and Group 2 (TAP-D) received bilateral TAP blocks in combination with dexamethasone. Opioid use in the post-anesthetic care unit, at 24 hours, 48 hours was recorded from patient charts.

Results/Outcomes: There were 14 patients in the TAP group and 10 patients in the TAP-D group. Adjusting for 9 confounders, TAP blocks with dexamethasone did not significantly change opioid requirements in PACU, at 24H or 48H post-op. There was a trend towards lower opioid use in the TAP-D group at 24H (-9.3mg; p=0.36), at 24-48H (-4.36mg; p=0.72), and in 48H total (-16.0mg; p=0.46). There was no difference in the number of patients reporting nausea (-0.2; p=0.36) or length of stay (-1.1; p=0.33).

Conclusions/Discussion: The preliminary analysis did not show significant improvement in opioid use in the first 48 hours post laparoscopic colorectal surgery with TAP-D blocks. A trend towards lower opioid use was evident in all our measured outcomes.

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