

Abstract ID: 1940.**Prevention of infectious complications in predicted severe acute pancreatitis (SAP) – a single center randomized controlled trial**

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Introduction: It's mostly accepted there's no need for routine antibiotic prophylaxis in mild cases of AP. Evidence of prevention of infectious complications in SAP is still controversial with imipenem showing potential benefit.

Aims: To investigate prophylactic use of imipenem for prevention of infectious complications in predicted SAP.

Patients & methods: Consecutive AP patients with APACHE II ≥ 8 were randomly assigned in a double-blind manner to receive imipenem 3x500 mg i.v. daily or an identical placebo ideally for ten days. Infectious complications including infected pancreatic necrosis, pneumonia, urinary tract infection (UTI), positive blood cultures, sepsis, and other infections were determined as the primary outcome. Exclusion criteria were prior AP, chronic pancreatitis, active malignancy, immune deficiency, active infection, concomitant antibiotic treatment within 72 hours before enrollment, pregnant and breastfeeding women, and patients <18 years. Concomitant treatment was given equally in both groups.

Results: A total of 98 patients were randomized, 49 to each group. Patients were similar according to demographics and average disease severity scores. Infective complications were present in 10/49 versus 12/49 patients ($P=0.81$). There was no significant difference in specific infective complications: infective pancreatic necrosis (3/49 vs. 2/49), pneumonia (3/49 vs. 2/49), UTI (3/49 vs. 5/49), positive blood cultures (1/49 vs. 3/49), sepsis (1/49 vs. 2/49), and other (4/49 vs. 3/49), respectively. We found no significant differences in mortality ($P=1.00$), organ failure ($P=0.39$), and local complications ($P=0.31$). Occurrence of mycotic infections was similar in both groups.

Conclusion: Our results add to available evidence there's currently no ground to support routine prophylactic use of antibiotics in predicted SAP.

Abstract ID: 1942.**Visceral obesity and passive drainage are risk factors of pancreatic fistula (PF) after distal pancreatectomy (DP)**

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Introduction: Predictive risk factors of clinically relevant (CR) PF after DP have not been consensually identified

Aims: To identify predictive risk factors of CR-PF following open and laparoscopic DP.

Patients & methods: Analysis of a prospectively maintained database of elective DP. Preoperative and intraoperative clinical data were collected. Radiologic measures on preoperative CT-scan included Visceral Fat Area (VFA), Total Fat Area (TFA), Subcutaneous Fat Area (SFA), pancreas density, retro renal fat thickness and Total Muscle Area (TMA: parietal+paraspinal+psoas). Sarcopenia was defined according to Prado (Lancet Oncol 2008) with a Surface Muscle Index $<38.9\text{cm}^2/\text{m}^2$ in female and $52.4\text{cm}^2/\text{m}^2$ in male. Occurrence of CR-PF as defined by ISGPF (grade B-C) was the main end point. All variables associated with a p value <0.1 in univariate analysis were included in multivariate analysis.

Results: From 2012 to 2016, 208 patients were included. CR-PF occurred in 31(15%). In univariate analysis, risk factors of CR-PF were: BMI $>25\text{kg}/\text{m}^2$ ($p=0.023$), a dilated main pancreatic duct ($>3\text{mm}$; $p=0.035$), open approach ($p=0.008$), ligation of main pancreatic duct ($p=0.027$), venous resection ($p=0.02$), blood loss $>150\text{ml}$ ($p=0.007$) and passive drainage using multichannel drain ($p<0.001$) while suction drainage decreased this risk ($p<0.001$). VFA $>92\text{cm}^2$ ($p=0.052$), TFA $>245\text{cm}^2$ ($p=0.080$) and soft pancreas ($p=0.072$) trend to increase the CR-PF risk. In sub-group analysis, obese sarcopenic patients had a higher risk to develop CR-PF ($p=0.009$). In multivariate analysis, VFA $>92\text{cm}^2$ (OR=3.057; IC95% [1.06-8.8] $p=0.038$) and multichannel passive drainage (OR=7.120; IC95% [1.7-29.3] $p=0.007$) were independent predictive factors of CR-PF.

Conclusion: Both visceral obesity and passive drainage increase the risk of CR-PF. Sarcopenia did not influence this risk, except in obese patients.

Abstract ID: 1949.**Surgical management of main duct IPMN and mixed type IPMN: an international survey and case-vignette study among experts**

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Introduction: The risk of malignancy increases up to 60% if the main duct (MD) is involved in intraductal papillary mucinous neoplasms (IPMNs). Therefore, most guidelines advice resection in surgically fit patients with MD-IPMNs or mixed type (MT) IPMN but consensus on partial or total pancreatectomy as optimal treatment is lacking. A survey was performed to identify the surgical strategy of international expert pancreatologists in order to guide the design of future studies and guidelines.

Aims: - Patients & methods: An online survey including case-vignettes was sent to 219 pancreatologists who had published on IPMN. Diagnostic approach, treatment- and surgical strategy were evaluated.

Results: Overall 66 surgeons (30.1%) and 28 gastroenterologists (12.8%) replied, 43% response rate. The majority worked in an academic hospital (93%), with a median of 15 years' experience in treating patients with IPMN. PD dilatation ($>5\text{mm}$, $<10\text{mm}$) in the total pancreas was considered a prerequisite for surgical resection by respectively 57.9% of the respondents. Of these, 45.5% would perform a total pancreatectomy, 25.5% a partial resection with frozen section and 25.5% a pancreatodoudenectomy. PD dilatation ($>5\text{mm}$, $<10\text{mm}$) in the head or tail was considered a prerequisite for surgical resection by 33.6% and 45.5% of the respondents.

Conclusion: This survey identified lack of consensus amongst international pancreatologists regarding the treatment- and surgical strategy in patients with MT- or MD-IPMN which should be addressed in future studies and guidelines.