complications compared to laparoscopic procedures. This suggests that the laparoscopic approach is the preferred approach, especially in patients with pulmonary comorbidities.

**Lighting the Way with Fluorescent Cholangiography in Laparoscopic Cholecystectomy: Reviewing 5 Years of Experience**

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**INTRODUCTION:** Laparoscopic cholecystectomy (LC) is the most common elective surgery in the US. Fluorescent cholangiography (FC) using indocyanine green dye (ICG) identifies extrahepatic biliary structures without direct cannulation of the common duct aiding the critical view of safety. ICG use has been standard at our institution for the past 5 years. We aim to describe trends for the largest single-center cohort of patients undergoing FC in laparoscopic cholecystectomy.

**METHODS:** A retrospective review of a prospectively maintained database identified patients undergoing laparoscopic cholecystectomy using FC at a single academic institution. Outcomes included operative time, conversion to open procedure, biliary injury, length of stay (LOS), mortality, and complications.

**RESULTS:** From April 2015 through December 2020, 690 patients underwent LC with FC; 74.9% were female; mean age was 50.1 years, and average BMI was 28.8 kg/m². Mean OR time was 69.0 minutes. There were no mortalities or common bile duct injuries. Morbidities included 2 cystic duct leaks and 2 retained common duct stones requiring endoscopic retrograde cholangiopancreatography (2.2% readmission rate). Yearly complication rates were not significantly different. 7 (1.0%) patients required conversion to open. In 2015, conversion to open rate was 4.4% and decreased yearly to 0% in 2020 (p = 0.073). Operative time and LOS also trended down (Figure).

**CONCLUSION:** Consistent use of FC during laparoscopic cholecystectomy improves outcomes. After 5 years of institutional experience with this technology, no common duct injuries occurred and conversion rates decreased significantly.

**Patients with Low Socioeconomic Status Are More Likely to Undergo Sleeve Gastrectomy vs Roux-en-Y Gastric Bypass: Analysis of a Statewide Claims Database**

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**INTRODUCTION:** Use of sleeve gastrectomy (SG) for weight loss has grown exponentially; however, clear indications for SG vs Roux-en-Y gastric bypass (RNY) are lacking. Certain populations may be more likely to undergo SG due to its simpler technique, regardless of appropriateness. We aim to examine underlying predictors of patients undergoing SG vs RNY across a single state.

**METHODS:** We queried the Colorado All Payers Claim Database for patients undergoing laparoscopic SG or RNY. Patients were stratified by the Distressed Communities Index (DCI), a ZIP code-based measure of socioeconomic status ranging from 0 (least distressed) to 100 (most distressed). High DCI was defined as the top quartile (≥75). We performed multivariable logistic regression, adjusting for demographics, insurance coverage, and comorbidities, to compare odds of undergoing SG vs RNY, with and without a random effect for hospital.

**RESULTS:** There were 5,313 patients included, with 3,195 (60.1%) undergoing SG and 2,118 (39.9%) undergoing RNY. On multivariable analysis, not controlling for hospital effect, higher DCI was associated with increased likelihood of undergoing SG (OR 1.88, p < 0.001), while rural residence was associated with increased odds of RNY. Certain comorbidities favored one procedure over the other (Figure). After adding a random effect for hospital, the OR for DCI was no longer significant.

**CONCLUSION:** Lower socioeconomic status, defined by a high DCI, is predictive of a patient undergoing SG. These associations disappeared after addition of a hospital-level random effect to modeling, suggesting that disparities may be due access to surgeons or systems with preference for one procedure.

**Figure.** Predictors of undergoing Roux en Y gastric bypass versus Sleeve Gastrectomy.