associated with improved OS in T1 and T2 (hazard ratio [HR] =0.76; p=0.010). Older patients (HR=1.06; p<0.001) and those with private insurance (HR=2.01; p<0.001) had worse OS (Fig.1).

CONCLUSION: Patient age and insurance were significant factors predicting procedure type. Patients undergoing LE were older with Medicare. LE was inferior to RR for achieving R0 resection and associated with worse OS, even after controlling for tumor and patient characteristics.

**The Impact of an Integrated Healthcare System on Racial Disparities in 30-Day Outcomes Following Colorectal Surgery**

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**INTRODUCTION:** Racial disparities in colorectal surgery outcomes have been extensively studied in the United States (US), and access to healthcare resources may contribute to these differences. The Veterans Health Administration (VHA) is the largest integrated healthcare network in the US, with the potential for equal access care to veterans. This study evaluates the impact of the VHA on racial disparities in 30-day colorectal surgery outcomes.

**METHODS:** Colon and rectal resections from 2008-2019 were retrospectively reviewed using the Veterans Affairs Surgical Quality Improvement Program database. Patients were categorized by race and ethnicity. Thirty-day outcomes were compared between these groups. Cases with “unknown/other” race/ethnicity were excluded.

**RESULTS:** There were 45,481 colon and rectal resections that met inclusion criteria: 29,547 (65.0%) Caucasian, 7,047 (15.5%) African-American, and 2,329 (5.1%) Hispanic patients. Caucasian and African-American races showed no statistically significant differences in outcomes. Compared to Hispanic ethnicity, African-American race had a longer median length of stay (7 vs 6 days; p<0.001) and operative times (3.23 vs 3.13 hours; p=0.005), but no difference in mortality and morbidity.

**CONCLUSION:** The VHA provides the benefits of integrated healthcare and access, which may explain the improvements in racial disparities compared to existing literature. However, veteran minorities still suffered from worse 30-day outcomes in this analysis. Further efforts beyond healthcare access are needed to mitigate disparities in colorectal surgery.

**Trends and Outcomes of Using Neoadjuvant Systemic Therapy for Clinical T4b-M0 Colon Cancer in the US: An Analysis of the National Cancer Database**

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**INTRODUCTION:** Traditionally, neoadjuvant therapy (NT) has played a limited role in the management of colon cancer. Recently, there has been a growing interest in using NT in patients with locally advanced tumors. In this study, we explored the trends and outcomes of using NT in the USA.

**METHODS:** The National Cancer Database (NCDB) was queried for patients with cT4bM0 colon cancer (2006-2016). Patients treated with NT were propensity-score matched to those treated with upfront surgery and adjuvant therapy (AT) for clinically node negative (cN-ve) or positive (cN+ve) disease (controlling for age, gender, race, comorbidity, and tumor location).

**RESULTS:** Colectomy for cT4bM0 colon cancer was performed in 8,130 patients (age 68 y, 54% females, 85% White, 60% cN+ve). Fifty-six percent received perioperative chemotherapy. NT was used in 7%. Over the study period, the use of NT increased from 4% (2006) to 15% (2016). Pathologic-downstaging after NT was noted in 46% and 3% for cN+ve and cN-ve, respectively. Factors associated with increased use of NT on multivariable analysis included younger age (odds ratio [OR]:0.96,CI:0.96-0.97), male gender (OR:1.25,CI:1.04-1.51), recent diagnosis year (OR:1.15,CI:1.11-1.19), treatment in an academic center (OR:2.45,CI:2.03-2.94), cN+ve (OR:1.21,CI:1.002-1.46), and tumors located in the hepatic
flexure (OR: 2.77, CI: 1.83-4.20, p < 0.001) or sigmoid colon (OR: 2.74, CI: 2.26-3.32, p < 0.001). NT was associated with lower overall mortality on multivariable analysis (HR: 0.36, CI: 0.61-0.42). On propensity-matched analyses, NT was associated with higher overall survival compared with upfront surgery + AT in patients with cN+ve (n = 201-each group; 5-y overall survival: 54% vs 40%, p = 0.025) (Fig.), but not in those with cN-ve (n = 275 in each group; 5-y overall survival: 64% vs 59%, p = 0.318).

CONCLUSION: The National use of NT for cT4bM0 colon cancer has increased significantly over the 10-year study period, particularly in academic centers. Patients with cN+ve appear to benefit most from NT, with pathologic downstaging noted in almost half of the patients and a higher overall survival than those treated with upfront surgery and AT.

Validity of Caprini Score in Postoperative Venous Thromboembolism in Inflammatory Bowel Disease
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INTRODUCTION: Patients with inflammatory bowel disease (IBD) have an increased risk of venous thromboembolism (VTE), especially perioperatively. Caprini score is a reliable risk assessment tool for VTE in the postoperative state. We evaluate the ability of the Caprini score to predict VTE in postoperative IBD patients.

METHODS: A retrospective study was performed using National Surgical Quality Improvement Project (NSQIP) data from 2010-2018. Patients with Crohn’s disease (CD) and ulcerative colitis (UC) undergoing elective surgery were categorized in 3 groups: complex pelvic, abdominopelvic, and small bowel procedures. Caprini scores were calculated using available perioperative characteristics, and patients were categorized as low, moderate, and high risk.

RESULTS: We identified 27,679 patients undergoing surgery for IBD. Postoperative deep venous thrombosis (DVT) rate was 1.43% in CD and 3.05% in UC. DVT occurrence was highest in complex pelvic operations in UC (87.9%, p < 0.001) and abdominopelvic operations in CD (71.59%, p < 0.01). In patients with CD and UC who developed VTE, Caprini score was low risk in 46.1% and 48.5%, and moderate risk in 51.1% and 52.4%, respectively. Less than 1% of all IBD patients were high risk.

CONCLUSION: Postoperative DVT rates in patients with IBD are high. Procedure type affects DVT rates for UC and CD, with an increased risk of DVTs in complex pelvic procedures for UC and abdominopelvic procedures for CD. Caprini score may underestimate the increased risk of postoperative VTE rates in IBD patients and should not be used as a predictor of postoperative VTE risk.

Where There Is Fat There Is Fibrosis: Elucidating the Mechanisms of Creeping Fat-Driven Stricture Formation
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INTRODUCTION: Crohn’s disease (CD) is a subtype of inflammatory bowel disease (IBD) characterized by transmural inflammation and creeping fat formation. Thirty percent of CD patients develop strictures, 80% of which will require surgery. Creeping fat (CF) forms adjacent to strictures, but whether it promotes stricture formation is unclear. Here, we present a novel surgical model of intestinal fibrosis and show by lineage tracing and selective fat ablation studies that creeping fat may drive fibrosis by generating fibroblasts.

METHODS: We developed a novel surgical model of CD fibrosis by creating antimesenteric colotomies. We performed lineage tracing of mature adipocytes in mice and characterized adipocyte-derived cells by immunostaining. Lastly, we selectively ablated CF adipocytes and assessed histologic features such as collagen deposition and bowel wall thickness.

RESULTS: Our surgical model phenocopies clinical features of human strictures. Lineage tracing of mature adipocytes in mice and characterized adipocyte-derived cells by immunostaining. Lastly, we selectively ablated CF adipocytes and assessed histologic features such as collagen deposition and bowel wall thickness.

CONCLUSION: Our colotomy model represents a novel approach to study intestinal stricture formation and CF without the long-term use of caustic agents. Lineage tracing demonstrates that CF adipocytes convert to fibroblasts that infiltrate the bowel wall (Figure 1L). CF ablation is sufficient to reduce stricture formation. Taken together, these findings suggest that CF may drive intestinal fibrosis, in part through the contribution of CF-derived fibroblasts.