publicly insured. PADLI had higher one-year ostomy closure rates (83.3% vs. 64.7%, p<0.01; Hazard Ratio=2.38 [95% Confidence Interval 2.10-2.69]; p<0.01) and shorter time-to-closure (median 82 days [IQR 53-145] vs. 165 [98-274]; p<0.01) relative to HP. PADLI resulted in increased unplanned readmissions (HR=2.88 [95%CI 2.40-3.46]; p<0.01), and fewer complications upon stoma closure (OR 0.62 [95%CI 0.49-0.78]; p<0.01) but not during the index admission (OR=1.17 [95%CI 0.96-1.44]; p=0.12).

**CONCLUSION:** Most patients undergo HP for acute diverticulitis in the U.S. Those who undergo PADLI are more likely to undergo ostomy reversal and experience fewer postoperative complications upon stoma reversal. In agreement with national guidelines, these data support increasing the utilization of PADLI in appropriate cases of acute diverticulitis requiring operative treatment.

**Surgeon Variability in the Adoption of Organ Preservation for Patients with Rectal Adenocarcinoma Treated at a Comprehensive Cancer Center**

**INTRODUCTION:** One of the main hurdles in widely adopting a watch-and-wait (WW) approach in rectal cancer patients who respond well to neoadjuvant therapy is the treating surgeon’s concerns about the long-term outcomes. In this study, we compare the long-term oncologic outcomes of rectal cancer patients treated by surgeons with variable adoption of WW at a comprehensive cancer center.

**METHODS:** We included patients diagnosed with clinical stage II/III rectal adenocarcinoma from January 2013 to June 2017 at Memorial Sloan Kettering Cancer Center who initiated neoadjuvant therapy (either with chemoradiation, chemotherapy, or a combination of both). Patient clinicopathological and treatment characteristics by surgeon were compared using chi-squared and Kruskal-Wallis tests. Univariable and multivariable cox regression models for disease-free-survival (DFS) were also performed.

**RESULTS:** 444 LARC patients treated with neoadjuvant therapy managed by 5 surgeons during this study period were included. Patient demographics and treatment were compared after grouping by the treating surgeon. Tumor distance from the anal verge, type of neoadjuvant therapy, and organ preservation (OP) rates were different between the groups (p=0.0072, p<0.0001, and p<0.0001; respectively). There was no difference in DFS after stratifying by the treating surgeon (p=0.2). On multivariable analysis, neither the type of neoadjuvant therapy nor the treating surgeon was associated with DFS.

**CONCLUSION:** While neoadjuvant therapy type and OP rates varied among surgeons, there were no meaningful differences in DFS. This data provides further support to the safety of WW to achieve OP in rectal cancer patients treated with neoadjuvant therapy.

**Surgical Management of Patients with Complex Perianal Fistula: Results of a US National Case-based Survey to Determine Future Educational Needs**

**INTRODUCTION:** Crohn’s-related perianal fistulas (CPF) are major contributors to lowered quality of life (QoL) for patients with Crohn’s disease. This study aimed to identify practice patterns and knowledge gaps in CPF management.

**METHODS:** To understand the perspectives of colorectal surgeons (CRS) managing patients with CPF, we developed a case-based survey related to management of initial presentation and recurrence of CPF. Surveys were distributed online during Sep/Oct 2020 to US CRS experienced with CPF (≥1 CPF patient/month).

**RESULTS:** Seventy-eight CRS responses were collected. In patients who initially presented with fistula, there was no standardized approach for CPF evaluation or classification. While the majority (71%) chose seton plus medical management as initial intervention, there was no standard approach to seton removal. No consensus existed on preferred medical/surgical treatment in patients with a partial biologic response or for recurrent fistula. CRS prioritized long-term CPF goals of improved QoL and avoiding major surgery/preserving continence, while fistula healing had the lowest priority. COVID-19 did not have a major effect on patient management. Barriers to optimal CPF management were perceived to be lack of effective medical therapies, poor surgical outcomes/complication risks, patient reluctance, delayed referral/diagnosis, and lack of guidelines/treatment algorithms. Significant barriers to multidisciplinary management included lack of access to CPF specialists and treatment plan communication, and difficulty coordinating care between specialists/centers. A lack of familiarity exists with newer/potential treatments.

**CONCLUSION:** There is no consensus on how to best manage CPF. Education is needed to improve outcomes in CPF treatment.

**The Association Between BMI and Nodal Harvest in Elective Colectomy for Colon Cancer**

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**CONCLUSION:** There is no consensus on how to best manage CPF. Education is needed to improve outcomes in CPF treatment.
INTRODUCTION: Obesity has been linked to the development of Colorectal Cancer and to increase morbidity. However, the impact BMI has on surgical staging through nodal harvest is not entirely understood.

METHODS: We queried the targeted colectomy NSQIP database from 2015 through 2019. The cohort was selected based on codes corresponding to elective colectomies for colon cancer. BMI was grouped into the 5 clinically relevant categories. Nodal harvest was dichotomized into <12 and ≥12 lymph nodes. A multivariate regression was utilized to evaluate the association between BMI and adequate nodal harvest controlling for key covariates.

RESULTS: A total of 35,039 patients were included. Median BMI was 29.02 mg/kg² (IQR, 24.37-32.44) with a median of 22 (15-27) lymph nodes harvested. The BMI groups with the highest adequate LN harvest were those <25 with 93.7% compared to 92.8% in BMI >25 (p=0.002). Right colon cancers had a higher rate of achieving adequate harvest compared to left, 94.8% vs. 90.8%, respectively (p <0.001). Right tumors had a higher rate of adequate harvest in the <25 groups, this frequency decreases as BMI increases and conversely for left tumors (p <.001). Inadequate harvest was higher for open approach (9.82%) compared to laparoscopic (6.12%) or robotic (6.6%) (<0.001). BMI ≥25 was associated with a 13% increase likelihood for an adequate nodal harvest (OR: 1.13, 95% CI 1.02-1.26).

CONCLUSION: This study associated lower BMI’s with a higher probability of achieving adequate nodal harvest. This can increase awareness in the risk of incomplete harvest in overweight and obese patients.

Colorectal Surgery Outcomes in Octogenarians and Older Patients: A NSQIP Analysis of 3224 Patients
Joy Ayemoba, MD, Gokhan Ozuner, MD, FASCRS FACS
New York-Presbyterian Brooklyn Methodist, Brooklyn, NY

INTRODUCTION: The life expectancy in the world is increasing. We analyzed outcomes in octogenarians and older patients undergoing major colorectal surgery.

METHODS: From 2017-2019, 169,895 individuals underwent colorectal surgery (as identified using CPT codes) within the NSQIP dataset. From this cohort, patients with any significant comorbid conditions (dyspnea, end-stage-renal disease, ventilator use, COPD, CHF, hypertension, disseminated cancer, chronic steroid use, or bleeding disorders) were excluded from analysis. 55,195 individuals were identified within the NSQIP data, and 3,224 octogenarians and older patients were identified. Using the study sample, descriptive analyses were performed with exploration and appropriate analysis (Chi-square v. T-test) of categorical vs continuous variables signifying preoperative patient characteristics and postoperative comorbidities. Univariate analyses were then conducted to find statistically significant variables in relationship to morbidity and mortality. The relationship between morbidity and age is to be further explored.

RESULTS: Octogenarians and older patients had increased morbidity and prolonged length of hospital stay. A preliminary regression model focused on the relationship between age and mortality in CRS found that every one-year increase in age was associated with increased odds of mortality when adjusted for preoperative patient characteristics (OR: 1.057, p<0.001 CI: 1.043-1.068). The final model for mortality and morbidity in relationship to age is pending.

CONCLUSION: Advanced age even in patients with no major comorbid conditions is associated with increased morbidity and mortality and prolonged LOS.

Decreasing Wound Infection and Deep Surgical Site Infection in Colorectal Surgery: The Benefits of Minimally Invasive Surgery and a Rigorous Perioperative Protocol
Rafael Pereza, DO, Paige C Adams, BA, Jaafar Elhagars, MD, Henry Schoonyoung, MD, FACS, John H Marks, MD, FACS
Lankenau Medical Center, Wynnewood, PA

INTRODUCTION: Colorectal surgery has the highest surgical site infection rate for abdominal surgery, 5-30%. We hypothesize that a minimally invasive surgical approach and use of standardized perioperative treatment path have led to a decrease in SSI rate.

METHODS: A prospectively maintained database of MIS colorectal resections at a single institution from 2000-2020 was queried. All patients received mechanical and po antibiotic bowel prep; surgery was performed minimally invasively using a clean-dirty technique. Superficial wound SSI and deep abdominal/pelvic SSI were analyzed and compared among multiple risk factors.

RESULTS: 2716 MIS colorectal resections were analyzed; mean age 61 years (17-95). 51% were women. Mean BMI was 27.3 kg/m² (13.6-51.6). 635 patients (23.4%) received neoadjuvant radiation. Superficial wound SSI rate was 0.77% (N=21). Abdominal/pelvic SSI rate was 2.7% (N=74). Overall SSI rate was 3.5% (N=95). Anastomotic leak rate was 1.22%. There was no difference in superficial and abdominal/pelvic SSI rate based on BMI (p = 0.79) or age (p=.56). Patients receiving neoadjuvant radiation and undergoing rectal resections had a statistically significant higher rate of superficial and deep infections (p<0.01). In multivariate analysis, radiation and rectal surgery still are more likely to develop SSI (p<0.01).

CONCLUSION: A standardized treatment path including mechanical and oral antibiotic bowel prep, MIS approach and strict clean/dirty techniques result in very low superficial wound infection rates (0.77%) and a lower SSI rate than found in the literature (3.5%). Rectal surgery and neoadjuvant therapy were associated with higher infection rates; age, obesity, and site of colon surgery were not.