Results Among 168 patients with ASUC, 54 (32.1%) required surgery and 114 (67.9%) received intravenous corticosteroids or rescue treatment. CT scan showed 121 (72.0%) patients had sarcopenia. Patients with sarcopenia had longer disease duration, more total parenteral nutrition, higher CRP level and lower quality of life. Although patients who required surgery had lower SMA, no significant differences were found in medical and surgical therapy between patients with and without sarcopenia. Patients with postoperative complications had higher preoperative white blood cell level and C-reactive protein, and a higher incidence of sarcopenia. Multivariate analysis showed that sarcopenia (odds ratio, 53.07; 95% confidence interval, 2.79–1010.03; $p=0.008$) was a negative predictor of postoperative complications in ASUC patients (table 1).

Abstract IDDF2019-ABS-0162 Table 1 Multivariate analyses of risk factors associated with postoperative complications for ASUC patients.

Characteristics	OR	95% CI	P value
Male	1.163	0.232–5.835	0.855
Preoperative white blood cell	17.666	2.036–153.274	0.009
Preoperative C-reactive protein	2.456	0.259–23.310	0.434
Sarcopenia	53.069	2.788–1010.032	0.008

ASUC, acute severe ulcerative colitis.

Conclusions The prevalence of sarcopenia was high in patients with ASUC. Sarcopenia was not a predictor of surgery, but a risk factor of postoperative complications in severe ulcerative colitis patients.

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PRELIMINARY RESULTS OF HIGH-RESOLUTION MANOMETRY IN DIAGNOSIS AND CLASSIFICATION FOR ACHALASIA

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Background Achalasia is a rare disease characterized by absent esophageal motility and disorder of lower esophageal sphincter (LES) relaxation. The Chicago Classification, version 3.0 presents the diagnostic criteria for achalasia using high-resolution manometry (HRM) as well as categorizes this disease into three types with different esophageal motility patterns.

Methods A case-series study was conducted at the Institute of Gastroenterology and Hepatology on patients suspected achalasia on upper endoscopy or esophageal barium X-ray. Symptom severity was evaluated by the Eckardt score before and after treatment. Achalasia was diagnosed and classified by HRM using the Chicago Classification version 3.0.

Results From April to December 2018, we recruited 20 patients (7 males and 13 females; the mean age were 35.9 ± 15.4). There were 4 patients (20%) diagnosed with absent contractility on HRM. In 16 achalasia confirmed patients, the percentage of type I, II, and III was 12.5%, 75%, and 12.5%, respectively. The mean Eckardt score before treatment was 6.6 ± 2.6 and there was no difference between achalasia and absent contractility groups. The integrated relaxation pressure within 4s (IRP4s) in achalasia group was high with the mean

value being 24.6 ± 6.3 mmHg and there was no difference among three types. There was a significant improvement of clinical symptoms with pre and post-treatment Eckardt score being 6.8 ± 2.8 and 2.1 ± 1.9 , respectively ($p < 0.05$). In 2 cases after surgery and balloon dilation, the LES pressure was normal but absent contractility and distal esophageal spasm were present on HRM.

Conclusions High-resolution manometry is a valuable exploratory test for definitive diagnosis, classification as well as follow-up after treatment on achalasia patients.

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THE MODIFIED PROGNOSTIC NUTRITIONAL INDEX (MPNI): A NEW RISK INDEX FOR PREDICTING CLINICAL OUTCOMES AFTER PERCUTANEOUS ENDOSCOPIC GASTROSTOMY

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Background Onodera's Prognostic Nutritional Index (O-PNI) is a screening tool derived from serum albumin levels (Alb) and total lymphocyte count (TLC). C-reactive protein (CRP) and blood urea nitrogen (BUN) levels were added to create the modified Prognostic Nutritional Index (mPNI). In this study, the utility of mPNI in predicting clinical outcomes after percutaneous endoscopic gastrostomy (PEG) was investigated.

Methods Based on multiple logistic regression analysis, mPNI was calculated using the equation $10 + 2 \times \text{Alb}(\text{g/dL}) + \text{TLC}(\mu\text{L})/1000 - \text{CRP}(\text{mg/dL})/2 - \text{BUN}(\text{mg/dL})/20$. ROC analysis was used to evaluate mPNI as a predictor for postoperative aspiration pneumonia, in-hospital mortality, 30-day mortality and 90-day mortality.

Results

Derivation group 306 patients, mean age 82.6 ± 10.0 years old, Alb 3.2 ± 0.5 g/dL, TLC $1357 \pm 586/\mu\text{L}$, CRP 2.5 ± 2.9 g/dL, BUN 26.9 ± 22.0 mg/dL, O-PNI 38.5 ± 6.3 and mPNI 15.1 ± 2.6 . Postoperatively, 69 patients developed aspiration pneumonia and 49 died before discharge, 22 within 30 days. AUC (area under the curve) for clinical outcomes summarized in table 1.

Abstract IDDF2019-ABS-0164 Table 1

	Aspiration pneumonia	In-hospital mortality	30-day mortality
Alb	0.576	0.665	0.662
TLC	0.604	0.618	0.683
CRP	0.630	0.659	0.682
BUN	0.600	0.676	0.745
O-PNI	0.606	0.683	0.701
mPNI	0.680	0.759	0.801

Validation group: 190 patients, mean age 81.4 ± 8.6 years old, Alb 2.8 ± 0.5 g/dL, TLC $1498 \pm 744/\mu\text{L}$, CRP 2.1 ± 2.7 mg/dL, BUN 22.8 ± 16.7 mg/dL, O-PNI 35.7 ± 6.8 and mPNI 15.0 ± 2.5 . Postoperatively, 26 patients developed aspiration pneumonia, 19 died before discharge and 25 within 90 days. AUC for clinical outcomes summarized in table 2.