of whether a better quality of care, including the use of rhPTH, will improve the biochemical control and decrease the rate of hypercalciuria and the risk of nephrolithiasis remains to be established.

Diabetes Mellitus and Glucose Metabolism

DIABETES COMPLICATIONS II

Improving Screening for Diabetic Retinopathy in a Resident Based Clinic

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Introduction Diabetic retinopathy is the leading cause of blindness in US Adults. In order to improve screening rates, we partnered with the Division of Ophthalmology and installed an onsite retinal camera at our primary care clinic. This led to an improvement in EMR reported screening rates from 20.5% to 44% over the first 3 months. We noticed that any fundus photo, whether gradable or not, led to an automatic annotation in EMR (EPIC) health Maintenance that screening had been completed. Abnormal or ungradable (quality too poor to interpret) retinal photos must be followed up with a complete ophthalmologic evaluation. We designed a chart audit to investigate further whether ungradable retinal photos were being followed up appropriately. **Methods** A retinal camera was installed in the clinic, and patients obtained DR screening during their routine visits from May through October 2018. The nursing staff received training on using the camera and ensuring image quality. These images were then sent to an Ophthalmologist and resulted within the work week. Patients with an abnormal or poor-quality retinal photo were contacted by their resident PCP. We did a retrospective chart review of patients with ungradable photos evaluating whether patients were contacted and whether they followed up with Ophthalmology in the 3 month period after the initial intervention. **Results** Of the 131 patients who received fundus photos in the study period, 29 (22%) had ungradable photos. Twenty-four of these patients were contacted and ophthalmology consults were placed for 22 patients. Eleven (38%) of these patients went on to complete screening with Ophthalmology within 3 months of the ungradable photo. Eighteen patients, or 62% of ungradeable photos, remained incorrectly identified as having completed retinopathy screening by EMR. **Discussion** Over reliance on EMR reporting features can lead to incorrect assumptions about DR screening. Based on this analysis, we need to design better interventions for following up on ungradable photos and ensuring appropriate follow up. One such intervention may be changing how EMR reports ungradable photos. EPIC is a widely used EMR in outpatient settings and other practices may be facing similar issues.

Adrenal

ADRENAL MEDICINE — CLINICAL APPLICATIONS AND NEW THERAPIES

A Multi-Center, Open-Label, Pivotal Phase 2 Study of Azedra® (HSA I-131-MIBG) in Patients with Unresectable, Locally Advanced or Metastatic Pheochromocytoma or Paraganglioma: Updated Long-Term Survival and Safety

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Background: Pheochromocytoma/Paraganglioma (PPGL) are rare neuroendocrine tumors with a 5-yr survival rate as low as 12%. There is a high unmet medical need for effective treatment options for patients with advanced disease. AZEDRA®, a high-specific-activity iodine-131 meta-iodobenzylguanidine (HSA I-131-MIBG), is the first and only FDA-approved therapeutic radiopharmaceutical agent indicated for the treatment of adult and pediatric patients with iobenguane scan positive, unresectable, locally advanced or metastatic PPGL who require systemic anticancer therapy. Methods: Patients with advanced PPGL who were heavily pre-treated and were ineligible for curative surgery or chemotherapy received a dosimetric dose followed by up to two therapeutic doses (each at 296 MBq/kg to a max of 18.5 GBq). The primary endpoint, defined as the proportion of patients with at least 50% reduction of all antihypertensive medication(s) lasting ≥6 months, was met and previously reported. Updated secondary endpoints including overall survival (OS) and safety are reported. Results: A dosimetric dose of HSA I-131-MIBG was administered to 74 patients. Of those, 68 patients received one therapeutic dose and 50 received two doses of HSA I-131-MIBG. Clinical benefit rates (objective tumor responses defined by RECIST 1.0 and stable disease) were observed in 71.4% and 98.0% of patients receiving one and two therapeutic doses, respectively. As of October 10, 2019, median survival time for all patients was 43.2 months (95% CI 31.4, >60). Median survival time was 19.3 months (95% CI 4.5, 32.4) and 49.1 months (95% CI 36.9, >60) in patients receiving one and two doses, respectively. The overall survival was 73.8% at 2 yrs, 47.5% at 4 yrs and 41.5% at 5 yrs. The most common (≥50%) adverse events were nausea, fatigue, and myelosuppression. Myelosuppressive events resolved within 4-8 wks without requiring stem cell transplantation. Late radiation toxicity included 7 patients with secondary malignancies (myelodysplastic syndrome (MDS), acute myeloid leukemia (AML), acute lymphoblastic leukemia (ALL), colon cancer, and lung carcinoma) of which MDS, ALL and AML were considered related to I-131