wiring. We found no correlation between glove perforation and sternal wound infection.

0513: DOES EXPLORATORY THORACOTOMY FOR NON-SMALL CELL LUNG CANCER (NSCLC) ADVERSELY AFFECT PATIENTS’ OUTCOME POSTOPERATIVELY?

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Aims: To determine our incidence of explorative thoracotomy for NSCLC and its influence on further management of patients & their survival.

Methods: Retrospective review of patients referred for lung cancer surgery over 2.5 years. Clinical data were collected on radiological/pathological staging and post-operative management including survival status.

Results: Between January 2008-August 2011, 418 patients underwent thoracotomy for primary lung cancer, of which 27 patients (6%) had inoperable disease. Of the inoperable cases, 4 (15%) had a pre-explorative mediastinoscopy and 22 (81%) were investigated with PET studies. Sixteen patients (59%) had radiological-advanced stage (IIA). Inoperability was due to stage migration, N2 disease, tumour invasion or poor physiological status intra-operatively. Subsequent treatments included adjuvant chemotherapy/radiotherapy (combined) in 16 patients (59%) of which 12 (75%) are still alive with an average length of survival of 9 months.

Conclusion: Our incidence of explorative thoracotomy is well within those reported in the literature. Over half of patients were still suitable for radical adjuvant treatment and 44% survived for an average 9 months post-surgery.

Surgical thoracotomy should not be denied for advanced NSCLC to avoid depriving patients the benefit of curative resection and if resection cannot be achieved then some patients are suitable for adjuvant treatments.

0308: THE USE OF HOMOGRAPHS IN THE OPERATIVE MANAGEMENT OF INFECTIVE ENDOCARDITIS HAS LOWER SHORT AND MEDIUM-TERM MORTALITY AND IMPROVED OVERALL OUTCOME COMPARED TO PROSTHETIC VALVES

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Aim: Infective endocarditis remains a challenging clinical entity, particularly with changing causative organisms. We aim to characterize the operative management, microbiology, operative mortality and long-term survival in a contemporary cohort of patients having surgery for IE.

Methods: We reviewed the records of 125 consecutive patients who had surgery for IE over five years (2006-2011), at a large tertiary cardiothoracic centre. The valve prosthesis, causative organism, in-hospital mortality, long-term survival and need for repeat surgery were examined.

Results: Cumulative Kaplan-Meier survival was 86.8% at one-year and 67.8% at five years. 101/125 (80.8%) patients had isolated valve surgery, 13/125 (13.6%) two valves and 7/125 (5.6%) three valves. Of the aortic valve IE, 24/66 (36.3%) patients had aortic homograft (LES 44.4%), 33/66 (50%) had tissue valve (LES47.7%) and 9/66 (13.6%) mechanical prosthesis (LES 23.3%). The use of Homograft as a valve substitute was more common in patients with annular involvement and intracardiac abscesses. In-hospital mortality for homograft was 4.5% vs. 8% for prosthetic valve p=0.01. There were no re-infections in the homograft group vs. 4.5% for prosthetic valve p=0.001.

Conclusion: In patients having operation for infective endocarditis, homograft valve replacement provided excellent short and medium-term outcomes with superior survival and freedom from re-intervention compared with prosthetic valve replacement.