therapy. We also studied the effect of patients' awareness as a possible tool to reduce the prevalence of errors. Prospective follow-up of 500 adult patients admitted for elective-surgery and were subjected to thromboprophylaxis therapy during peri-operative period. Data were collected on daily base, computed and analyzed. Failure of thromboprophylaxis application was recorded in 46%,48.59%,51.43% among those required stocking, Enoxeparine and heparin . Analysis proved that 93% of patients had at least one-error, 77% a combined error while 37.08% failed to be mobilized when appropriate. Patients who were aware of the value of therapy had remarkably less prevalence of errors($p< 0.016$) Patients' led thromboprophylaxis through ample teaching, training and illustrative leaflets at time of admission increasing awareness of seriousness of the problem can be another effective tool reducing the risk of human errors in busy understaffed modern surgical wards.

SACRAL NEUROMODULATION FOR MANAGEMENT OF INTRACTABLE CONSTIPATION

Ben Liu, Abhiram Sharma, Graham Duthie. Hull and East Yorkshire Hospital NHS Trust

Introduction: Sacral nerve neuromodulation (SNN) has been used in managing severe constipation with mixed results. We looked at our experience of SNN to try identify the cohort of patients suitable for this intervention.
Methods: Patients with severe constipation and failure of conservative management were considered for SNN. Investigations included colonic visualization, intestinal transit times, proctogram and manometry. Temporary stimulation lead was placed in sacral foramen in eligible patients. Pre and post stimulation bowel diaries were compared. Patients with = 50% improvement in bowel diaries and quality of life had permanent implant. Patients were followed up with bowel diaries.
Results: Temporary SNN were conducted in 21 patients. Significant bowel diary improvement was seen in 12 (57%) patients ($p<0.01$). Factors predictive of poor response were delayed orocaecal transit and anismus. 11 permanent SNN implants have been performed. No major side effects were observed. 3 patients had re-operations. Improvements in bowel diaries have been maintained over a median follow-up period of 23 months.
Conclusion: SNN can provide long-term symptom relief in selected patients with severe constipation. Improvement in bowel diary with temporary wire placement is an excellent predictor of response with permanent implant. Our experience has helped us devise a constipation treatment algorithm for future use.

BODY MASS INDEX GREATER THAN 25 DOES NOT ADD EXTRA DAYS TO THE LENGTH OF HOSPITAL ADMISSION

G.W. Beattie, C. Austin, S. MacGowan. Royal Victoria Hospital Belfast

Objective: Our aim was to compare the length of hospital stay for all cardiac surgery patients in relation to their body mass index.
Methods: We retrieved data from the dendrite register from 2002 to 2009. There were 6195 cases covering all cardiac surgery operations. Good quality data was available for 5883 cases. Body Mass index was divided into Underweight[16.5-18.4], Normal[18.5–24.9], Overweight[25–30], Obese[30.1-40], Morbidly Obese[>40.1].
Results: 39 patients were classed as underweight, 1513 normal, 2807 overweight, 1451 Obese, and 73 morbidly obese. The median postoperative stay for all patients was 7 days, spending one day in ICU and HDU. The Mean length of stay was 15 days for the underweight group, 14 days for the normal group and 11 days for the other three groups. The morbidly obese spent more hours ventilated in CSICU at a mean of 16 hours. The discharge day was broken down into groups. Morbidly obese patients who get discharged day 0 to 4 have a low mean Euroscore [1.73], if they are discharged after day 11 the Euroscore is significantly higher[6.76].
Conclusions: The median time to discharge when operating on patients with a BMI greater than 25 is not significantly increased from normal patients.

ANATOMICAL VARIATION IN THE POSITION OF THE UMBILICUS AND THE IMPLICATIONS FOR LAPAROSCOPIC SURGERY

D. Fawkner-Corbett [1], J.A. Nicholson [2], T. Bullen [2], P. Cross [1], D. Bailey [1], M.H. Scott [2]. [1] University of Liverpool Medical School; [2] Department of General Surgery, Whiston, Merseyside

Background: In current surgical practice the umbilicus is accepted as being in a constant position at the midpoint of the abdomen. This is the rationale for the umbilicus being selected for the initial port in conventional laparoscopic surgery and the sole port employed in single port laparoscopic cholecystectomy. We propose the umbilicus is not an anatomical constant and thus should be reconsidered as an automatic insertion point in laparoscopic cholecystectomy.
Methods: 119 patients were prospectively recruited in a surgical outpatient clinic over a four week period. A ratio of xiphoid process to umbilicus and xiphoid process to pubic symphysis was calculated for each (SUM value). Height, weight and presence of abdominal scars were also recorded. The populations mean age was 49.6 years (31.4-67.8). There was an equal male:female ratio.
Results: Results found a mean SUM value of 0.53(0.46-0.60), 58% had a “central” umbilicus (SUM 0.50 $\pm$ 0.05). Of the remaining 42%, 34% had a “low” umbilicus (SUM = 0.56) and 8% a “high” umbilicus (SUM = 0.44).
Conclusion: Results show a large proportion of subjects had a central umbilicus but this was by no means an anatomical constant. Large variation was demonstrated which has implications for more accurate initial camera port placement in laparoscopic cholecystectomy.

“BARE BELOW THE ELBOWS” – PROFESSIONALISM VS INFECTION RISK

J. Baxter, O. Dale, J. Morgan, A. Morritt, J. Pollock. Derby Hospitals NHS Foundation Trust

Objectives: In 2007 the Department of Health published the document “Uniforms and Workwear: An evidence base for developing local policy” which is the basis for the national “bare below the elbows” dress code. Our study aimed to establish what the public think about hospital work-wear with regard to professionalism and infection risk.
Methods: 480 hospital patients and visitors were surveyed. They were shown photographs of male doctors in three examples of work-wear: surgical scrubs, shirt and tie and bare below the elbows. They were asked to select which best answered each question: 1) Who do you think looks the most professional? 2) Who do you think poses the greatest risk of transmitting a hospital infection to you? 3) How would you like your doctor to dress?
Results: Question 1) Shirt and tie 77%, scrubs 22%, bare below the elbows 1% ($p < 0.01$). Question 2) Bare below the elbows 37%, scrubs 33%, shirt and tie 30% ($p > 0.05$). Question 3) Shirt and tie 64%, scrubs 33%, bare below the elbows 3% ($p < 0.01$).