Conclusions: CSS is a superb resource if utilised properly. We have provided the legal framework and protocols required along with a detailed review of practical considerations to enable successful CSS.

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0290: THE SAFETY, FEASIBILITY AND UTILITY OF 3-DIMENSIONAL C-ARM CONE-BEAM COMPUTED TOMOGRAPHY WITH XPERCT POST-EVAR

Aim: 3-Dimensional C-arm Cone-beam (CAB) Computed Tomography is emerging as a useful adjunct for quality control during EVAR. We examined the safety, feasibility and utility of a new 3-D CAB, XperCT Allura FD20 system (Philips, Best, The Netherlands).

Methods: All patients in this prospective study underwent conventional post-EVAR uni-planar angiography (CPEA), and additional post-EVAR XperCT-on-table. Patients with eGFR <30 mls/min/1.73m2 or previous renal interventions were excluded. We examined the impact of XperCT on additional on-table interventions and the correlation of XperCT observations with the routine 30-day surveillance CTA.

Results: Between April 2010 and July 2013, 51 patients underwent CPEA and XperCT post-EVAR. XperCT detected new findings not identified by CPEA in 9 patients (17.6%) patients (1 Type1A endoleak, 5 Type2 endoleaks, 3 suboptimal limbs). Of these 4 (7.8%) underwent further on-table intervention for correctable technical error. Following satisfactory XperCT, 7 (13.7%) patients had new surveillance CTA findings at 30-days (5 new Type2 endoleaks, 2 limb occlusions). Renal function remained unchanged. Median time for XperCT acquisition was 11(6-23) minutes.

Conclusions: XperCT is feasible, safe and maybe a useful adjunct to guide further intervention on-table immediately post-EVAR for quality control but at present 30-day post-EVAR surveillance CTA may not be replaced by XperCT.

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0774: SIMPLE PERIOPERATIVE INTERVENTIONS CAN MINIMISE THE RISK OF PHARYNGOCUTANEOUS FISTULA FOLLOWING TOTAL LARYNGECTOMY – EXPERIENCE AT A SINGLE TERTIARY INSTITUTION
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Introduction: Pharyngocutaneous fistula following total laryngectomy contributes to patient morbidity and mortality from prolonged hospitalisation, delayed oral feeding, increased risk of catastrophic vascular haemorrhage and delays to commencement of adjuvant radiotherapy. The experience at our institution has evolved with respect to standardisation of perioperative management of these patients since mid-2013 that has seen a marked reduction in the fistula rate. The changes instituted are simple interventions related to meticulous pharyngeal closure technique, a novel dressing technique and prolonged postoperative metronidazole administration.

Aim: To assess the independent effect of the change of practice on the fistula rate at our institution.

Methods: Here we present a retrospective review of a cohort comprising consecutive patients undergoing total laryngectomy between January 2010 and August 2015.

Results: The total fistula rate was 10 percent in the cohort of 80 patients. A dramatic reduction can be seen comparing the groups before and after the change of practice - 16.3 percent (8/49) versus 0 percent (0/31). The groups are otherwise similar accounting for known predictors including salvage surgery. Here, we present a statistical analysis of the attributable effect of each standardised intervention.

Conclusion: Simple interventions can seemingly reduce the fistula rate in favour of more morbid procedures.

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0543: CT FINDINGS OF SURGICALLY PROVEN INTERNAL HERNIAS POST LAPAROSCOPIC GASTRIC BYPASS (LRYGB) – A RETROSPECTIVE ANALYSIS

Background: Diagnosing internal hernia after gastric bypass is still demanding, even with advanced CT scanning

Methods: Patients who had diagnostic laparoscopy for abdominal pain after LRYGB over the period from 2013-2015 in our institute were included.

Results: Out of 23 patients, 16 patients had IH found during diagnostic laparoscopy. Six (37.5%) of those patients had their Peterson and mesenteric defects closed during primary surgery. Median age at primary procedure was 43 years. Median BMI at primary procedure was 46.5 kg/m2. The median time of presentation with abdominal pain post bypass was 1.5 years. At the time of the presentation the median excess weight loss was 68% and median BMI 33.3 kg/m2. Commonest sign at CT was “Swirl sign” 7/16 (44%) and “mesenteric oedema” 7/16 (44%). 6/16 (38%) had 2 or more signs while 5/16 (31%) had no signs.

Seven cases of no internal hernia. Even in these patients Swirl sign was present in 3/43% and mesenteric oedema in 2 (29%). 3/43% had 2 or more of 9 previously documented CT signs pre-operatively. Pre-operatively 3/43% had no signs at CT.

Conclusion: This study shows that the absence of CT finding should not preclude laparoscopic examination to rule out IH.

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0463: REDUCING THE RISK OF ATRIAL FIBRILLATION AFTER ANATOMICAL LUNG RESECTION

Aims: De novo post-operative atrial fibrillation (POAF) may increase morbidity, hospital stay and healthcare expenditure. This study aims to determine the perioperative factors correlating with POAF and whether these may be modified to reduce its incidence.

Methods: The records of all patients undergoing anatomical lung resection from July-December 2015 were retrospectively reviewed. Patients treated with long-term antiarrhythmic therapy (excluding beta-blockers) or a history of arrhythmia were excluded.

Results: POAF occurred in 13.9% (29/209) of patients at a mean of 3.97 days post-operatively and significantly increased hospital stay (7.0 ± 4.8 vs. 11.5 ± 6.6 days, p = 0.0014). No correlation was found with gender, hypertension or ischaemic heart disease. However, older age (p = 0.003, r² = 0.04), post-operative infection (p < 0.0001; Chi² = 15.6) and an open rather than VATS approach (open 20/105 (19.0%); VATS 9/94 (9.6%); p = 0.032) were found to be significant uni- and multi-variate predictors of POAF occurrence. Notably, 27.6% (8/27) of patients failed to be cardioverted and remained in AF on discharge, 4 of whom required long-term anticoagulation.

Conclusions: Increased adoption of VATS procedures reduces the overall incidence of POAF after anatomical lung resections. More rigorous control of modifiable risk factors such as stringent monitoring and early treatment of post-operative infection may further reduce POAF and its associated morbidity.

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0403: NON-OPERATIVE MANAGEMENT OF LOWRECTAL CANCER WITH COMPLETE RESPONSE TO STANDARD NEO-ADJUVANT CHEMO-RADIO-THERAPY (CRT)
Introduction: 15-20% of low rectal cancers achieve full response to long course (LC) chemoradiotherapy (CRT). A protocol for non-operative management of “complete responders” was started in January 2007 for this select group of patients. It was the patient’s free choice of declining surgery after being fully informed on three occasions.

Methods: 14 patients were followed up after complete response. A local protocol [no formal national guidelines] was used involving five years of regular Magnetic Resonance Imaging (MRI), Endoscopic Ultrasound (EUS) and Examination Under Anaesthetic (EUA) of anorectum under general anaesthetic. Colonoscopy and Computer Tomography (CT) chest-abdomen-pelvis (CAP) were done at year two and five.

Results: Seven are still disease-free and under surveillance. Three had recurrence; two underwent abdomino-perineal excision of the anorectum and one underwent ultra low anterior resection, all with R0 resections and still disease-free. Four were unfit for surgery and had transanal procedures with suspicion of disease; all had tumour-free specimens, are still disease-free and under surveillance.

Conclusions: This protocol and management is fully in line with current literature and best evidence and there has been no compromise to patient care. However, this study is low numbers and larger trials/studies are needed.

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0390: SURGICAL MANAGEMENT OF AMIODARONE-INDUCED THYROIDITIS

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Introduction: Amiodarone can be a life-saving medication; however it also has multiple side effects, for example; amiodarone-induced thyroiditis (AIT). AIT is rare, (incidence of 3-5% [1]), complex and life-threatening. AIT can cause significant cardiac dysfunction and cardiac failure. Medical management in Australia consists of cessation of amiodarone, prescription of thiouanidies, percholates and steroids.[2] However, a small sub-group don’t respond and are referred for a semi-elective total thyroidectomy. These are complex surgical patients with hyperthyroidism, the potential for thyrotoxic crisis, and end-stage cardiac failure. However without surgical removal of their thyroid gland they will continue to deteriorate, with a mortality rate of 30-50%. [3]

Method: Due to the rarity of this condition, a case series was used to evaluate the role of surgical management of AIT in those who have failed medical treatment.

Results: Patients were analysed with respect to; duration of trial of medical treatment, pre-medical treatment cardiac function, pre- and post-operative cardiac function, surgical complications and survival. Their results were compared to those of non-AIT patients undergoing total thyroidectomy.

Conclusions: Total thyroidectomy in patients with AIT shows comparable clinical outcomes to total thyroidectomies for other indications. It also restores euthyroidism and reduces mortality risk in patients with AIT.

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0456: SURGICAL LEARNING ACTIVITIES FOR HOUSE OFFICERS - DO THEY IMPROVE THE SURGICAL EXPERIENCE?

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Aims: To ascertain whether house officers (HOs) attain a more satisfactory surgical rotation experience when they perform basic surgical learning events. We also sought to establish how many and which learning events HOs achieve and the effect on their surgical experience.

Methodology: A questionnaire listing 20 learning activities and questions regarding satisfaction with overall experience was disseminated to HOs in the UK and Ireland who had completed ≥3 months of surgical rotations. Satisfaction with surgical experience was dichotomised in order to perform logistic regression using R Studio software v0.98.

Results: 115 doctors completed the questionnaire with 17% achieving at least half of the learning activities. On multivariate analysis, satisfaction with surgical experience was statistically significantly associated with an increased number of completed learning activities (odds ratio 24.3, $p<0.002$), independent of one’s interest in surgery or satisfaction with teaching received.

Conclusion: Surgical HOs who performed basic surgical learning activities reported significantly greater satisfaction with surgical rotations. Therefore, we recommend facilitating HOs completion of these activities as this will ensure that basic surgical competencies are achieved and that HOs will be more satisfied with their surgical experience.

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0305: SURGICAL SAFETY CHECKLIST TRAINING: A NATIONAL STUDY OF UNDERGRADUATE MEDICAL AND NURSING STUDENTS

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Aims: To use the World Health Organisation (WHO) surgical safety checklist is recognised to reduce human error peri-operatively. Most medical and nursing graduates join teams responsible for care of surgical patients; therefore surgical-safety education should start at university. This study aimed to investigate undergraduate experience of SSC training.

Posters of Distinction Prize Session 3

0306: A PROSPECTIVE MULTICENTRE STUDY OF OUT OF HOURS EMERGENCY UROLOGY: IMPLICATIONS FOR FUTURE WORKFORCE PLANNING

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Background: In 2014 a BAUS survey of 160 Urology departments concluded that up to 50% were reliant upon General Surgery middle grade support at night. The future of General Surgery cross-cover for other specialties is under considerable and constant debate. Our study aims to establish and further characterise contemporary levels of out of hours (OOH) Urological activity.

Methods: We prospectively gathered data on OOH Urology referrals for a 2 week period in 4 UK hospitals. Together these served a combined population circa 2 million patients.

Results: Overall 173 OOH referrals were received. Referrals were most commonly made between 17:00 - 23:00hrs (47%). The majority were related to existing in-patients (59%). Other sources included local Emergency Department, Surgical Assessment Unit and Primary Care (25%, 12%, and 4%). Urolithiasis (13%), Uro-sepsis (12%) and haematuria (10%) were the most common reasons for referral. Only 6% required urgent operative intervention - 45% of this activity being acute scrotal exploration. Telephone advice was offered in 41%. In-patient review was required for 42%.

Conclusions: We conclude that the majority of OOH Urological referrals do not require operative intervention. This data could be considered when constructing future models of emergency care.