resection for metastatic GIST, with relation to the recently proposed pre-treatment classification by Cananzi et al.

Methods: A retrospective case note analysis was performed. Pre-treatment disease extent was classified as per Cananzi et al: type I-II non-metastatic, resectable disease; III metastatic (synchronous) resectable disease; IV unresectable disease. The primary outcome was 5-year survival; secondary outcomes were disease free intervals and treatment practices.

Results: Twelve patients underwent liver resection for metastatic GISTs. Pre-treatment, patients were classified as: type I in 3; type II in 5; type III in 2; type IV in 2. Five-year survival was 100%, 60%, 50% and 100% respectively. Type I to III patients were treated with surgical resection only. Type IV disease was downstaged with neo-adjuvant TKIs prior to resection. The disease free interval was 73, 28, 28 and 53 months respectively (mean 36 months).

Conclusions: Neo-adjuvant TKIs therapy for metastatic GIST has a potentially significant role in improving 5-year survival and disease free intervals.

0445: A CLOSED LOOP AUDIT DEMONSTRATES GREAT IMPROVEMENT IN ACUTE PANCREATITIS CARE

Peter Davies, Hareth Bader, Chris Babiesy, Debashish Maitra. St Helens and Knowsley NHS Trust, Merseyside, UK.

Introduction: The British Society of Gastroenterologists (BSG) updated guidelines on the management of acute pancreatitis in 2005. This audit aimed to improve acute pancreatitis care in accordance with these guidelines.

Methods: An initial audit of all 39 patients with acute pancreatitis in October-December 2011 was undertaken. Improvements were made through arranging group teaching for junior doctors, extra cholecystectomy lists, a 7-days per week ultrasound service (5-days previously) and through arranging group teaching for junior doctors, extra cholecystectomy lists, a 7-days per week ultrasound service (5-days previously) and combined microbiology and surgical ward rounds. Liaison with gastroenterologists improved ERCP availability. A retrospective re-audit was undertaken of all 50 patients in February-March 2013 to complete the audit cycle.

Results: Modified Glasgow Score was completed in 98% of re-audit cases (85% previously). Antibiotic prescription was considered appropriate in 90% (47%). Gallstone pancreatitis was managed by cholecystectomy, either as an inpatient or within two weeks, in 77% (10%). Ultrasound was performed within 24 hours of admission in 66% (28%). ERCP was delayed in 2% (5%) and overall mortality was 8% (10%).

Conclusions: Acute pancreatitis care was improved following several changes. Current care follows recommended guidelines but there is room for improvement, notably in improving ultrasound access and managing gallstone pancreatitis.

0502: POST OPERATIVE SURGICAL DRAINS AFTER PANCREATOCAUDENECTOMY: SINGLE VERSUS DUAL DRAINAGE

Jamal Ghaddar, William Paxton, Chris Briggs, Somaiyah Aroori. Derriford Hospital, Plymouth, UK.

Introduction: The placement of one or more abdominal drains after pancreatecoaudenectomy is common practice with the rationale that this facilitates early diagnosis of complications.

Methods: We retrospectively reviewed 182 patients chosen at random out of a pool of 260 patients who had a pancreatecoaudenectomy between 2006 and 2013.

Patients were subdivided into two groups; those with one drain (group 1) and patients with two drains (group 2). Data was then analysed according to demographic factors such as age/ gender and peri-operative factors such as type of pancreatic anastomosis, date of drain removal, complications, means used to diagnose and treat complications, length of stay, clinical details, cancer origin and histology reports.

Results: There were 37 patients in group 1 and 145 patients in group 2. The length of hospital stay was significantly shorter in group 1 (13.16 vs 15.39 days, P<0.005). There was no statistical difference in the rate of overall complications, intervention or re-admission in both groups.

Conclusions: The use of one drain after pancreatecoaudenectomy may facilitate earlier discharge without increasing morbidity, mortality, re-admission and intervention rate.

0728: ROUTINE COAGULATION SCREENING IS UNNECESSARY PRIOR TO ERCP IN NON-JAUNDICED PATIENTS: A MULTI-CENTRE STUDY

Sarah Walker1,2, Katie Mellor1, Jonny Nicholls1, Richard Egan1, Michael Stechman1, 1University Hospital of Wales, Cardiff, UK; 2Princess of Wales Hospital, Bridgend, UK.

Introduction: Guidelines suggest performing coagulation screening prior to endoscopic retrograde cholangiopancreatography (ERCP). We hypothesise that coagulation is rarely deranged in the absence of biochemical jaundice.

Methods: All ERCP procedures performed at two centres during a 16 month period were assessed. For each patient demographic data, pre-procedure bilirubin and prothrombin time (PT), diagnosis and bleeding complications were recorded. Exclusion criteria were: incomplete records; anti-coagulation therapy or inherited coagulopathy.

Results: The cohort was divided into jaundiced (n=419) and non-jaundiced (n=374) groups for analysis. Seven per cent (n=28) of jaundiced patients had a significantly prolonged PT (>16.8 seconds = INR of >1.5). One non-jaundiced patient had significantly prolonged PT, whilst 5.9 per cent (n=22) had a mildly raised PT (above normal range); none of these had bleeding complications. A significant difference in PT between groups was seen (mean ±SD 13.0 ±6.3 vs. 11.0 ±1.2 seconds; p<0.001 t-test). The diagnosis, ERCP procedures, and bleeding complications were equivalent between groups and centres. The approximate cost of coagulation tests in the non-jaundiced cohort was £7,500.

Conclusions: Patients with normal bilirubin levels rarely have deranged coagulation suggestive of acquired coagulopathy. A negative bleeding history and normal liver function tests makes coagulation screening an unnecessary and expensive investigation.

0801: FITNESS TO DRIVE ADVICE AFTER ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY (ELC) – WHOSE RESPONSIBILITY IS IT? A SURVEY OF CAR INSURANCE COMPANIES

Michael Courtney, Bussa Gopinath, Duncan Light, Milind Rao. University Hospital of North Tees, Stockton-on-Tees, UK.

Introduction: Easily accessible online advice regarding return to driving following ELC is inconsistent. Driving too soon is unsafe and risks invalidating a patient’s car insurance; hence patients are often advised to check their own insurance company’s policy. This study aimed to review UK insurance companies’ advice regarding return to driving following ELC.

Methods: An online search identified 126 car insurers; each was emailed asking whether the policyholder can return to driving following ELC, and advice as to how he/she would know they were fit to drive.

Results: 26 companies were not contactable online so excluded. Of the remaining 100 companies, 62 responded: 61% stated their regulations, 39% would not communicate without a confirmed policy. All companies offering information stated that a doctor must determine the policyholder’s fitness to drive, or timescale in which they cannot. I stated that the policyholder needed to be able to perform an emergency stop, the rest did not comment.

Conclusions: Insurance companies place the responsibility of determining fitness to return to driving with the patient’s doctors. It is the doctor’s duty to ensure that patients have access to this information, and that information is documented. If publically available information is to be utilised, there is a need for standardisation.

0843: HEPATIC TRANSARTERIAL CHEMOEMBOLISATION IN EAST LANCASHIRE: ACHIEVING INTERNATIONAL STANDARDS

Kenan Kursumovic, Sam Byott, Ambreen Kausar, David Chang, Neil Wilde, Duncan Gavan. Royal Blackburn Hospital, Blackburn, UK.

Introduction: Hepatic Transarterial Chemoembolisation (TACE) for non-resectable Hepatocellular carcinoma (HCC) therapy exploits the preferential blood supply from the hepatic artery for delivery of antitumour therapy. It is also used for other primary or metastatic liver malignancies. We enacted a comprehensive review of the TACE service at a district general hospital in East Lancashire, United Kingdom with a focus on patient selection, complications and survival rates.

Methods: A retrospective review was performed from 2007 to 2012, against clinical practice guidelines published by CIRSE (2012) and SIR (2012).