referred source had improved from 5% to 70%, named consultant from 65 to
95%, and clinical examination from 80% to 100%.

Conclusion: The introduction of a clerking proforma has significantly
improved the quality of admission documentation for acute surgical pa-
tients, and has now been formally implemented in our department.

0935: USE OF A LEVEL ONE TRAUMA WARD IN A MAJOR TRAUMA
CENTRE IN ITS FIRST 12 MONTHS

R. Heard*, Chesterfield Royal Hospital, UK

Aim: To establish how the new 8-beded level one ward (D9) was being
utilised at East Midlands Major Trauma Centre during its first year of
existence.

Methods: Data was collected retrospectively from the ward admissions
book and cross-referenced with the Nottingham TARN database to ensure
accuracy.

Results: 403 patients were admitted to D9 within the 12 months
studied. Some were readmitted, resulting in 466 admissions total. Me-
dian length of stay was 3 days (range 0-33), although 32 patients were
admitted for less than 24 hours. 45% admissions (n=212) were directly
from ED; 34% (n=159) from higher level (level 2 or 3) wards and 54
admissions post-operatively from theatre. The remainder originated
from level 0 wards, other hospitals or did not have a prior destination
noted. 42% (n=198) patients were discharged home from D9; 33%
(n=154) were transferred to level 0 wards; only 3 patients died; the
remainder were discharged to other hospitals or higher level wards. 30
patients were readmitted to D9, with 83% (n=25) being readmitted back
from higher level wards.

Conclusion: Most admissions to D9 originated from ED/higher level
wards, were of short duration and resulted in either discharge home or
transfer to higher/lower level wards as appropriate.

0942: THE SIMPLE ANKLE FRACTURE FIXATION: EXPLORING THE
CONTROVERSIES

E. Gillott*, P. Ray†, 1 Royal National Orthopaedic Hospital, UK; 2 Royal Free
Hospital, UK

Aim: Ankle fractures are common with a UK annual incidence of ~10,000/
year (Van Staai et al, 2001). Fixation is generally required to restore the
fibula length and integrity of the mortise in unstable fracture. Fixation of
“simple ankle fractures” are index cases used to assess those seeking se-
lection to and to check progress within, an orthopaedic training post, yet
controversy remains with regard to almost every step of the treatment
pathway.

Methods: We conducted an anonymous pilot survey via “survey monkey”
of 30 questions relating to ankle fracture fixation practice.

Results: We obtained 42 responses from CT2 to Consultant level.
Unanimous consensus was eluded on all points. Post-operative immobi-
lisation had the closest agreement (41/42) followed closely by sandbag use
in cases of doubt (2/3). Unanimous consensus was eluded on all points. Post-
onoperative immobi-
lisation had the closest agreement (41/42) followed closely by sandbag use
in cases of doubt (2/3). Unanimous consensus was eluded on all points. Post-
onoperative immobi-
lisation had the closest agreement (41/42) followed closely by sandbag use
in cases of doubt (2/3).

Conclusion: Most admissions to D9 originated from ED/higher level
wards, were of short duration and resulted in either discharge home or
transfer to higher/lower level wards as appropriate.

0955: LITIGATION OF COMPARTMENT SYNDROME COMPLAINTS:
RETROSPECTIVE REVIEW OF 5 YEARS OF NHS ORTHOPAEDIC CLAIMS

E. Gillott*, J. Machin, H. Krishnan, S. Sarken, J. Bhamra, T. Briggs. Royal
National Orthopaedic Hospital, UK

Aim: Compartment Syndrome is a surgical emergency. Prompt diagnosis
can limit the sequelae and potentially save the limb.

Methods: We analysed all NHSLS (National Health Service Litigations
Authority) orthopaedic-related claims 2006-2012 (5706 anonymised
claims) for reference to compartment syndrome.

Results: 65/5706 claims related to complaints regarding compartment
syndrome. Failure or delay to diagnosis was the most common allegation
(72%). Mean age of complainant was 33 years (range: 6–71 years). There
was a 4:1 male predominance. 8 cases were upper limb, 37 lower limb with
20 cases unspecified. 38/65 cases closed (settled); 9 cases settled with no
monetary cost to either party and a further 29 at a cost of £5,3m aggregate.
Costs to defend all cases was £306,000. Ten complainants alleged resultant
amputation of the affected limb. 4/10 cases closed 3 of those were awarded
damaged; mean monetary cost/patient of £807,000

Conclusion: Compartment syndrome is rare. Diagnosis is clinical and
based on a high level of suspicion. Delay in treatment can negatively affect
outcome and add to the financial burden of the NHS. Education of health
care professionals regarding compartment syndrome must be targeted not
only to reduce litigation costs, but also to improve patient outcomes.

0965: PILOT AUDIT OF CURRENT TRAUMA LOAD IN A DISTRICT
GENERAL HOSPITAL

B. Lineham*, M. Lee, M. Gough. Scunthorpe General Hospital, UK

Aim: Trauma care is regionalised into major trauma centres (MTC) with
clear criteria for central transfer. As a result, a DGH should see minimal
major trauma. Our aim was to describe trauma team activation in a DGH
and utilisation of resources.

Methods: A&E department software was used to identify cases where
trauma-team activation had occurred over a 3-month period. Mechanism,
injuries, imaging, length of stay and outcome were collected.

Results: We identified 11 episodes of trauma-team activation. These were
for 2 paediatric cases and 9 adult cases. The most frequent mechanism was
RTC. Four patients were brought to the DGH against guidelines. Of these,
one was transferred to the MTC and the others observed in the DGH.
Median length of stay was 1 day for those brought to the DGH appropri-
ately vs 1.5 for those who met MTC transfer guidelines.

Conclusion: Our DGH sees a low volume of trauma, but a third of this
should be triaged direct to the MTC. We plan to extend this audit to capture
our full scope of activity since the introduction of the trauma network.

0968: DEVELOPMENT OF A MODEL TO PREDICT A NORMAL APPENDIX
AT LAPAROSCOPY FOR RIGHT ILIAC FOSSA PAIN

M. Lee*, E. Nofal, T. Wilson. Doncaster Royal Infirmary, UK

Aim: Negative appendicectomy remains relatively common and has an
associated rate of morbidity. Current predictive tests and models are
designed to identify which patients with right iliac fossa pain have appendicitis. We set out to develop a model to identify patients
who are likely to have a normal appendix in the context of right-iliac
fossa pain.

Methods: Previous audit identified 467 consecutive laparoscopic appendi-
cectomies. Complete demographic data and laboratory investigations were
available for 299 of these. Variables were analysed using multivariate
analysis and a binomial logistic-regression model was derived. Validation
was performed on an independent set of 58 laparoscopic appendicectomies.

Results: Multivariate analysis confirmed age (OR 0.95), white cell count
(OR 0.83) and bilirubin (0.94) as significant predictors of a normal ap-
pendix. Pseudo r2 was 0.28. Percentage probability of normal histology
was calculated and a ROC curve was plotted, showing good discrimination
(AUC=0.85). The optimum cut off was at 51% probability of a normal ap-
pendix. These findings were confirmed in the validation group where the
cut-off showed sensitivity and specificity of 0.84 and 0.86 respectively.

Conclusion: This model has potential to identify patients where the
appendix might be left in-situ and should be further evaluated in the clinical
setting.

0994: CONSULTANT COVER ON AN ACUTE SURGICAL GP ADMISSION
UNIT—DRIVING DOWN WAITING TIMES IN A NORTH-WEST HOSPITAL

N. Hossain*, M. Berry, S. Ashraf, M. Hartley. Royal Liverpool Hospital, UK

Aim: There has been a drive to introduce senior support early on in
the assessment of acute surgical patients. RCS Guidelines state that consultant-
led services represent best practice. Standards: RCS guidelines state all emergency surgical patients should be reviewed by a consultant surgeon at least once every 24 hours.

**Methods:** All patients seen in EAUU GP unit had demographics, time of arrival, time of senior review. Data for 200 patients was retrospectively collected and analysed before introducing a consultant-led service in May 2014. Data for 360 patients was collected following this.

**Results:** 42.6% of patients were male, 57.4% female. Median age was 46. The service evaluation revealed that patients were waiting a median of 2 hours 20 minutes for a senior review. 39.5% of patients were being admitted to hospital via this clinic. Following intervention, median time for senior review was 1 hour 10 minutes. Rate of admission was 39.5% before and 38.3% after.

**Conclusion:** RCS standards were already being met. The service evaluation saw a reduction of 50% in waiting time for senior review. There was no significant reduction in patient admissions.

**Posters: Upper-Gastrointestinal Tract Surgery**

**0055: THE EFFECTS OF IMMUNONUTRITION IN UPPER GASTROINTESTINAL SURGERY: A SYSTEMATIC REVIEW AND META-ANALYSIS**

C.S. Wong, a, b; E. Aly, a; University of Edinburgh, UK; University of Aberdeen, UK

**Aim:** The beneficial of immunonutrition on overall morbidity and mortality remains uncertain. We undertook a systematic review to evaluate the effects of immune-enhancing enteral nutrition (IEN) in upper gastrointestinal (GI) surgery.

**Methods:** Main electronic databases [MEDLINE via Pubmed, EMBASE, Scopus, Web of Knowledge, Cochrane Central Register of Controlled Trials (CENTRAL) and the Cochrane Library, and clinical trial registry (Clinical-Trial.gov)] were searched for studies reported clinical outcomes comparing standard enteral nutrition (SEN) and immunonutrition (IEN). The systematic review was conducted in accordance with the PRISMA guidelines and meta-analysis was analysed using fixed and random-effects models.

**Results:** Nineteen RCTs with a total of 2016 patients (1017 IEN and 999 SEN) were included in the final pooled analysis. IEN significantly reduced post-operative wound infection (risk ratio (RR) 0.69, 95% confidence interval (CI) 0.50 to 0.94). Although, the combined results showed that IEN had a shorter hospital stay (RR -2.51 days, 95% CI -3.47 to -1.55), there was significant heterogeneity observed across these studies. There was no statistically significant benefit on other post-operative morbidities of interest (e.g. anastomotic leak) and mortality.

**Conclusion:** IEN decreases wound infection rates and reduces length of stay. It can be recommended as routine nutritional support in upper GI surgery.

**0108: LAPAROSCOPIC TRANSGASTRIC SUBMUCOSAL DISSECTION FOR EARLY GASTRIC NEOPLASIA**

J. O’Callaghan, a, A. Folaki, B. Braden, B. Gromo, Oxford University Hospitals, UK

**Aim:** Peroral endoscopic submucosal dissection is technically challenging, particularly at the gastro-oesophageal junction. We present two cases of laparoscopic transgastric submucosal dissection as an alternative for the management of early neoplasia at the cardia.

**Methods:** The first case (female aged 76) had previous endoscopic mucosal resection with persistent focal high grade dysplasia on biopsies, the second (male aged 64) had an inconclusive endoscopic biopsy suspicious for malignancy. Both cases were offered laparoscopic transgastric endoluminal surgery. Standard laparoscopic equipment was inserted transabdominally and into the stomach under vision. Three trocars were placed into the gastric body for the laparoscopic camera and two instruments, providing an excellent approach to the gastro-oesophageal junction. The lesions were marked circumferentially, raised by submucosal injection and resected by submucosal dissection. The three gastrostomies were closed by laparoscopic sutures.

**Results:** After an excellent recovery the first patient was discharged on post-operative day 1; histology showed low grade dysplasia. The second patient was discharged on post-operative day 2; histology revealed poorly differentiated adenocarcinoma (pT1b).

**Conclusion:** The excellent visualisation, improved instrument handling and versatility provided by this novel technique facilitates endoluminal resection of lesions at the gastro-oesophageal junction that are beyond the scope of peroral endoscopy.

**0158: THE SURGICAL MANAGEMENT OF ACUTE UPPER GI BLEEDING: EXPERIENCES FROM A DISTRICT GENERAL HOSPITAL**

M. Rashid, F. Moroni, S. McLeish, G. Campbell, J. Bardgett, J. Round, C. McMullan, R. Clark, D. De Las Heras, C. Vincent, A. Palmer. Raigmore Hospital, UK

**Aim:** Acute upper GI bleeding (AUGIB) is the most common reason for emergency gastroenterological admission to hospital, with only 2% patients requiring surgical intervention. Our aim was to review those patients undergoing surgery after presenting with AUGIB.

**Methods:** Data was collected retrospectively for all patients between March 2008 and March 2013. Outcomes were compared to the UK Comparative Audit of AUGIB.

**Results:** 328 patients presented with AUGIB during the study period. 65.9% were male and 34.1% female. The mean age was 65 years, Glasgow-Blatchford score 8.4 and 30-day mortality 5.2%. In total, 11 patients (3.4%) underwent surgery. 1 patient proceeded straight to surgery. The remaining ten patients underwent surgery following repeat bleeding. 3 patients underwent 2 UGIE before proceeding to surgery and the remaining 7 proceeded to surgery after 1 UGIE. Mortality in those undergoing surgery was 9% (1/11), which was considerably lower than in the UK audit. 5 patients were felt to be too frail for surgical intervention and were palliated. These patients tended to be older (mean age 80.2 vs. 69.4 years) than those undergoing surgery and have more co-morbidities.

**Conclusion:** Surgery for AUGIB is infrequent. Our results suggest that the appropriate selection of cases is important.

**0168: AWARENESS OF UPPER GASTROINTESTINAL BLEED GUIDELINES AMONGST FOUNDATION TRAINEES**

S. Nisar, M. Peter. Bradford Royal Infirmary, UK

**Aim:** Acute upper GI bleeding (UGIB) is a common cause of admission and carries a high mortality rate. NICE recently published guidance for managing acute UGIB. We assessed the awareness of this guidance.

**Methods:** A short online survey comprising 10 questions was used. The survey was emailed to foundation doctors in our trust.

**Results:** Pre-endoscopy - 57% stated they would use the Blatchford scoring system, whilst 43% chose the Rockall. Post-endoscopy - 23% stated they would use the Blatchford, whilst 77% chose the Rockall. 54.3% of the respondents stated they would not continue low dose aspirin after haemostasis had been achieved. 71.4% stated they would start antibiotics at presentation. Regarding variceal bleeding - only 45.7% replied they would start antibiotics at presentation. 68.6% stated they would stop terlipressin after 5 days. For patients who rebleed 94.3% of respondents understood a repeat endoscopy is an option.

**Conclusion:** This survey is evidence that a large proportion of junior doctors are not aware of the latest NICE guidelines related to the management of UGIB. This in turn may impact on patient care. This also highlights the difficulty and the importance of keeping abreast of latest guidance and evidence for junior doctors.

**0472: IS ROUTINE GROUP AND SAVE INDICATED FOR DAY CASE LAPAROSCOPIC SURGERY?**

P. Thomson, J. Ross, S. Mukherjee, B. Mohammadi. University College Hospital, UK