

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 thionamides, 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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0316: 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.

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Posters of Distinction Prize Session 3

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

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Aims: Use of 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.

Method: An 8-item electronic questionnaire was distributed to 32 medical and 72 nursing schools. Medical and nursing analyses were conducted separately, and only final-year responses were included.

Results: 1,459 medical students from 22 universities, and 1,879 nursing students from 31 universities completed the survey. 37.8% of medical and 52.3% of nursing students received teaching on the checklist, whilst 6.3% of medical and 4.0% of nursing students were formally examined on it. 72.9% of medical and 66.1% of nursing students understood its purpose. There was a significant relationship between receiving training and understanding in both cohorts ($p < 0.0001$). Understanding varied according to inclusion in the Time Out. Medical students were more likely to be included than nurses.

Conclusion: Undergraduate surgical safety checklist training does not meet the WHO standards, with wide variations in experience. Knowledge of perioperative patient checks, and participation in safety protocols, are important skills that should be taught at undergraduate level.

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1278: DOES SPLIT-SITE WORKING AFFECT TRAINING?

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Aim: Service rationalisation in the NHS has led to clinical teams covering multiple hospital sites. We evaluate referral trends before and after the centralisation of Urology services at our institution and its impact on junior doctor training.

Methods: A prospective analysis of all referrals over 3 months was performed before and after the reconfiguration of our department to a single site. Training requirements were outlined as per the intercollegiate surgical curriculum programme (ISCP) syllabus.

Results: Before: Of 256 referrals, 36% were for advice, 41% required admission and 23% required intervention. The commonest pathologies encountered were stone disease, urinary tract obstruction and haematuria. **After:** Of a total of 222 referrals, 40% were for advice, 38% were for admission and 22% for intervention. The commonest pathologies requiring intervention were for urinary tract obstruction, stone disease and testicular pain.

In both time periods, the referral pattern and operative spread did meet the ISCP requirements.

Conclusions: Service rationalisation reduced the overall number of referrals to urology, without alternating their nature. Surgical opportunities before and after the move correlated with the national requirements for Urologists in training.

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0804: INTRAVENOUS FLUID THERAPY IN THE ADULT SURGICAL PATIENT

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Aims: The prescribing of intravenous (IV) fluid is a mainstay of care for patients across the country. We aimed to analyse the adherence of our unit to the NICE guidelines. We also sought to assess the understanding of IV fluid therapy among Foundation Year (FY) doctors.

Methods: This was a closed loop audit. Data was retrospectively collected for patients in a 95-bed General Surgical unit who had been receiving IV fluid for over 24 h. FY doctors were approached to complete a questionnaire about IV fluids. The intervention was in two parts: a one-hour teaching session followed by the NICE elearning module on IV fluids. Data collection was then repeated 3 months later.

Results: Of the FY1s surveyed, 47% knew the values for sodium in 1 L of Hartmann's fluid. IV fluid prescriptions contained excess fluid (patients were on average 1.5 L in excess) with excess sodium (mean of 130 mmol),

excess chloride and insufficient potassium. After intervention, the average patient was only 500 ml positive and sodium excess had reduced to 45 mmol.

Conclusions: IV fluid knowledge is poor and this is reflected in prescriptions. This simple and reproducible intervention produced a marked improvement in knowledge and prescriptions and will ultimately improve patient safety.

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0937: CAN NEWLY APPOINTED CONSULTANTS ACHIEVE NATIONAL STANDARDS IN COLORECTAL CANCER SURGERY?

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All primary colorectal cancer resections performed in the first 15 months of practice of three newly appointed consultant surgeons were prospectively audited and their outcome data compared to National Bowel Cancer Audit Standards. Demographics and outcomes measures were collected from October 2014 - December 2015.

58 patients underwent primary resection. 37.9% of patients were ≥ 75 years old. 24% of resections were performed as emergency or expedited cases. Compared to national data, patients had a higher elective ASA grade (37.9% \geq ASA 3 vs 21.5%). 53.4% underwent laparoscopic, or hand-assisted laparoscopic resection despite more advanced pathological staging (86% \geq pT3 vs 74.9%). 20.7% had metastases at diagnosis compared with 8.9% nationally.

82.8% of resections went to HDU or ITU post-operatively compared to 32.5% nationally. Median length of stay was 7 days, 30-day mortality was 3.4%, despite a mean CR possum score of 5%. 85% of resections were R0 and mean lymph node yield was 28.

Newly appointed consultants can achieve national standards of care in colorectal cancer resections from the start of their practice, even with a patient cohort exhibiting more advanced disease at presentation and higher peri-operative morbidity than the national average.

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1362: ENDOSCOPIC AND MINIMAL INVASIVE SURGERIES FOR SELLAR AND PARASELLAR TUMORS: CADAVERIC DATA

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Aim: Aim of this study is to assess assumed advantage of the pure endoscopic or endoscopic assisted or Microscopic supraorbital key hole approach. The idea is to measure visibility and accessibility to avoid the surgical complications.

Method: We will perform eight dissections on eight cadaver heads. This dissections integrated an operating microscope, endoscope, and neuro-navigation. Comparison was made between visibility and accessibility of sellar and parasellar region in both approaches.

Results: Our measurements of the formalin fixed heads including each side; the mean \pm SD from the bone margin to anterior communicating artery = 68.56 ± 6.00 , to ipsilateral internal carotid artery = 74.24 ± 7.76 , to contralateral internal carotid artery = 82.85 ± 7.50 , to basilar bifurcation = 86.16 ± 5.11 , to optic chiasma = 75.11 ± 5.82 , to ipsilateral anterior clinoidal process = 65.69 ± 6.62 , to ipsilateral posterior clinoidal process = 74.3 ± 7.29 , to ipsilateral optic canal = 63.73 ± 6.13 .

Conclusion: Using endoscope alone during conducting the keyhole approach is better/or no advantage over Using the endoscope as an assistance tool. Our recommendations are to use the introduced