

barrier which prevented patients from receiving surgery. Referral forms were considered unwieldy. Appropriate BMI thresholds for surgery were expressed as 46kg/m², or 43kg/m² with comorbidity, nearer to NICE recommendations.

Conclusion: This identified a consensus for lower eligibility thresholds, more funding, easier referral, outreach services to remote practices and more information provided to primary care and patients. Surgeons require direct referral and broadly support NICE guidelines.

0578 PDS FOIL PLATE: ITS APPLICATION IN NASAL SURGERY

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Aim: To evaluate functional and cosmetic outcomes after use of polydioxanone foil in nasal and septal surgery.

Methods: Retrospective analysis of 60 patients in whom polydioxanone foil was used over a two year period.

Results: Polydioxanone foil was used in a variety of different procedures, including septoplasty, septorhinoplasty and closure of septal perforation. 49% of procedures were post-traumatic. Unperforated foil was used in 96% of cases. There were no acute complications. Two patients required revision surgery (3.3%). The majority of patients achieved satisfactory functional and cosmetic results.

Conclusion: PDS foil is safe to use in the nose, and has a range of applications in nasal reconstructive surgery.

0580 FLUID AND ELECTROLYTE MANAGEMENT: UNDERGRADUATE PREPARATION AND AWARENESS

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Aim: Perioperative fluid management is routinely performed poorly by junior doctors, and is a major cause of iatrogenic morbidity and mortality. The recent ASGBI GIFTASUP guidelines provide explicit surgical guidance, particularly advocating routine use of balanced crystalloids. Poor knowledge amongst junior doctors has been demonstrated. However, no studies have assessed adequacy of undergraduate preparation. This survey sought to do so.

Method: An 18 point questionnaire was distributed to all final and penultimate year medical students in Oxford and Cambridge. 100 responses were received.

Results: There were no differences between universities. Students had received a mean 2.7 hours teaching on fluid management and felt this insufficient. 16% were aware of the GIFTASUP guidelines. 86% knew serum electrolyte concentrations, however, just 53%, 19% and 15% knew the content of 0.9% saline, Hartmann's and gelofusin. 89% could calculate 24 hour fluid requirements, but only 50-60% could do so for electrolytes. 0.9% saline was the preferred crystalloid for 45%; 37% thought the choice of balanced/unbalanced crystalloid was irrelevant. Significant minorities could not identify relevant clinical considerations for prescribing fluid. Students were, however, reasonably confident in prescribing fluids.

Conclusions: Our survey suggests both the need and opportunity for improvement in undergraduate preparation for surgical fluid management.

0583 A COST EFFECTIVE ANALYSIS OF THE MANAGEMENT OF EPISTAXIS

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Introduction: Epistaxis is the most common ENT emergency and is often treated by nasal packing. Traditionally, these patients have been admitted at least overnight. We analyse a protocol for the outpatient management of such patients.

Methods: Retrospective audit of epistaxis admissions from April 2009 to March 2010 to establish how many patients could potentially be managed as outpatients (allowed home with anterior nasal packing in-situ attended for subsequent outpatient management) based on modified Worthing Hospital criteria.

Results: Of the 72 admissions, 16 were for observation, 56 had anterior nasal packing. If the modified Worthing Hospital criteria had been applied, 35% of patients could have avoided admission.

Discussion: The cost of an overnight inpatient stay costs approximately £315 per day. We conservatively estimate an £8000 saving per year in our department with the introduction of the protocol.

With the increasing focus on healthcare costs we need to look at novel ways of cost saving while still providing high quality care. Here we present a simple and effective way of managing those patients who would traditionally be admitted.

0587 PROTOCOL DRIVEN TREATMENT OF DVT: DOES IT PROVIDE THE BEST RESULTS FOR PATIENTS WITH ILLIOFEMORAL DVT

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Aims: Deep vein thrombosis (DVT) is common, causing significant morbidity and mortality. DVT is usually managed using validated protocol, with treatment characteristically being delivered within a community setting. Illiofemoral DVT increases the risk of developing the post-thrombotic syndrome (PTS) some evidence suggests that these may be best treated with catheter-directed thrombolysis (CDT) to reduce the risk of PTS. We aimed to assess the effect of protocol / community delivered care for DVT on a potential treatment option for iliofemoral DVT.

Methods: We identified 490 outpatients that underwent DVT directed venous duplex between October 2009 and March 2010 within a large teaching hospital trust. Suitability for CDT was determined using well established criteria, based on national guidelines and international randomised studies. Positive scans were investigated to establish if outpatient treatment was given.

Results: Of the 490 outpatients, 93 (40 men) had evidence of DVT, of these 38 were iliofemoral. Twenty-two were suitable for CDT. None underwent CDT; 12 were anticoagulated as outpatients, 9 were admitted for anticoagulation and treatment of concurrent illness, 3 were not anticoagulated.

Conclusions: A significant proportion of patients deemed suitable are not offered CDT. For this to occur it needs to be incorporated into current treatment protocols.

0589 SHOULD WARFARIN BE DISCONTINUED BEFORE ENDOVENOUS LASER TREATMENT (EVLV)?

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Aim: EVLT has been shown to be a safe procedure. Since EVLT is a procedure with no skin incisions, stopping warfarin prior to the procedure seems unnecessary. Our aim was to determine if warfarin should be discontinued before EVLT.

Methods: Retrospective analysis of two consultant practice with respect to warfarin therapy on EVLT patients between Jan 2004-Dec 2009. One of the consultants routinely stopped warfarin at least 3 days prior to EVLT and other consultant continued warfarin. 810-nm diode laser was used.

Results: There were 38 patients in Warfarin Withheld (WW) group and 30 in Warfarin Continued (WC) group. The mean age was 64.7 (32-80) years in WW and 61.9 (25-85) years in WC group. The average length of vein treated and laser energy used was comparable in both the groups. There was only one complication in WW group (n=1, 2.6%), which was phlebitis. There were more minor complications in WC group (n=7, 23.3%) (p=0.0266, Fisher's exact test). These complications were haematoma (n=1), phlebitis (n=4) and numbness (n=2). The post-EVLT ablation rates were similar in both the groups.