Conclusion: The results were accessible, useable and reliable, shown by the LIDA tool. The information required a high level of education, shown by the Gunning-Fog Index and Flesch Readability Score.
The best three websites for patient self-education about mitral valve replacement are: http://www.drugs.com/cg/mitral-valve-replacement-inpatient-care.html, http://www.nhs.uk/conditions/Aorticvalvereplacement/Pages/Whatisitpage.aspx, http://www.bhf.org.uk/heart-health/treatments/valve-heart-surgery.aspx

0683: STARTING & EVALUATING A ROBOT-ASSISTED VATS PROGRAMME: PILOT PHASE

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Aim: The Freehand ™ robot scope holder has been recently released. We sought to assess the feasibility of implementing and using this robot-assisted telescope holder in VATS. This is first use in thoracic surgery.
Methods: Following dry-lab training of the consultant and theatre team by an experienced trainer we introduced the system into the operating room. Non-lobectomy patients were considered for robot-assisted VATS (R-VATS). 27 consecutive VATS patients were selected. 22 procedures were completed by R-VATS. The procedures were 9 wedge resections, 7 pneumothorax, 2 lung volume resections (LVRS), 3 empyema and 1 pleurectomy for mesothelioma.
Results: Surgical time (including on table-robot positioning): 50 - 115 min (mean 82). Total operating room time (including robot set-up/take down): 65 - 140 min (mean 111). R-VAT cases by consultant with assistant available but hands-off: 21/22. R-VAT cases by trainee with consultant scrubbed:1/22
Conclusions: Dry-lab preparation allowed robot position to be optimized. Implementation was rapid and safe. Consideration of robot placement and port position is critical. The robot gave a stable, non-wandering view. Assistants observed the procedure, but were not required to participate. Since these procedures can be conducted by a single operator there are manpower implications. Operative and theatre times are acceptable.

0801: THERMO-REACTIVE CLIPS DO NOT PREVENT STERNAL WOUND INFECTION IN OBESE PATIENTS AFTER CARDIAC SURGERY

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Aim: We have previously advocated using thermo-reactive clips (TR-clips) for reducing deep sternal wound infection (DSWI) after median sternotomy. We analyzed our data to clarify whether a benefit existed in obese patients.
Methods: We retrospectively reviewed our institutional database of patients who underwent cardiac surgery. All patients with a BMI =/>30 between 2008-2011 were included.
Results: 847 patients -66% had sternal closure with TR-clips and 34% with sternal wires. Pre-operative demographics and risk factors for sternal wound infection were similar except a greater proportion of men received TR-clips (74% vs 62% p=<0.001).
There was no difference in the rate of superficial wound infections (4.5% TR-clips vs 3.4% wires p=0.58). However, the incidence of DSWI was greater (TR-clips 3.6% vs wires 1% p=0.04). The rate of repeat surgery to treat DSWI was also higher (TR-clips 1.6% vs 0% p=0.03). Multivariate analysis showed TR-clips to be an independent predictor of DSWI –odds ratio 3.88: 95% CI 1.07-14.07 (p=0.03). Propensity score matching of the two groups (to account for baseline differences) resulted in 263 patients per group. Once matched, there was no difference in the rate of any sternal wound infection.
Conclusions: In obese patients TR-clips do not prevent sternal wound infection.

0805: A SURVEY OF THE MANAGEMENT OF POST-OPERATIVE ATRIAL FIBRILLATION IN CARDIAC CENTRES ACROSS THE UK

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Aim: European guidelines have been written on the management of post-op atrial fibrillation (AF). We sought to determine the variability in practice of post-op AF management in cardiac surgical centres across the UK.
Method: 32 centres responded to a questionnaire survey on post-op AF management following conventional cardiac surgery. Results were collated and analysed.
Results: Only 9 (28%) units had a formal written policy. A further 17 (53%) felt an 'unofficial' unit policy existed. 6 (19%) units used surgeon specific preferences. Where a formal policy existed all but one centre used Amiodarone 1st line. Sotalol was the most common alternative in units where individual surgeons differed in practice. Regularly encountered medications were Amiodarone, Sotalol, Bisoprolol and Digoxin. Overall 13 different medications were cited.
DC cardioversion was used at all centres in cases of haemodynamic instability. At some centres it was used for stable non-responders to medical therapy but timing varied greatly (1-5 days). Requirement for anticoagulation or transoesophageal echo to exclude LV thrombus was variable between units.
Conclusions: In the UK management of post-op AF varies between and within units. There may be benefits from formalization of unit policies to reduce variability and ensure current best practice is followed.

0889: CABG & SURGICAL INFECTION. OBSERVATIONS FROM A SCOTTISH CARDIOTHORACIC UNIT

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Objective: To audit the rate of surgical wound infection after coronary artery bypass surgery and compare it with latest literature.
Method: Retrospective analysis of signicant sample of patients who underwent coronary artery bypass graft (CABG) from January 2011 to January 2012.
Results: A statistically significant sample was taken from a pool of 317 patients operated during the above interval. To achieve a 95% CI, 174 notes were randomly screened and possible risk factors for surgical infection evaluated. Both sternal wound and the graft donor site were taken into account for rate of surgical site infection (SSI). The presence of diabetes or chronic kidney disease did not confer increased risk of SSI, while a history of cancer within previous 5 years from surgery and a documented acute kidney injury in the post-operative period carried increased risk of SSI, as independent risk factors.
Conclusions: The rate of SSI after CABG in our department is estimated as 3.4% for the sternal site and 4.6% for the donor site. The rate of deep sternal infection is 1.7%. Post-operative renal injury was correlated with SSI, possibly indirectly, determining increased length of hospital admission. Second generation cephalosporins remain a valid choice in cardiac surgery antibiotic prophylaxis.

0929: AUDITING COMPLIANCE WITH ANTICOAGULATION GUIDELINES AFTER HEART VALVE SURGERY

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Aim: Following heart valve surgery, patients often require life-long anticoagulation and local & national guidelines have been published. An ongoing audit was conducted to assess compliance with these guidelines and the accuracy of discharge documentation.
Method: During each cycle, data was collected from the local PATS database on 100 consecutive patients undergoing valve surgery. The standard was 100% compliance with guidelines and accuracy of documentation was assessed for anticoagulation therapy, duration and INR. The audit was presented at local Clinical Governance meetings and action plans implemented.
Results: First cycle (2009): 80% patients were treated according to guidelines and 82% had accurate documentation. Subsequently, guidelines were included in the junior doctor induction and the need for accurate documentation emphasised. Second cycle (2010): 90% followed guidelines and 78% of discharge summaries were accurate. Recommendations included incorporating a drop-down box into the electronic discharge and displaying a guidelines poster in the junior doctors' office. Third cycle (2012): 81% followed guidelines with 93% accuracy of discharge summaries. 9% patients were treated with antiplatelet therapy rather than warfarin after mitral repair.