palliation and long term survival respectively. Survival analysis was undertaken with Kaplan-Meier analyses (Mantel-cox).

**Results:** 160 patients were identified (median age 74.5; male:female 1.8:1). Primary site colonic in 56, rectal in 104 and metastases in 102. Overall median survival was 50 weeks. 71 patients had palliative chemotherapy. Palliative R2 resections were undertaken in 29 patients and 62 patients defunctioned. 69 patients had no surgical intervention. Absence of metastasis did not confer a significant survival benefit (p=0.1) while chemotherapy significantly improved survival (p=0.001). Palliative resection significantly improved survival compared to defunctioning and non-surgical management (p=0.05); and conferred a significant survival benefit compared to defunctioning alone (p=0.036).

**Conclusions:** Chemotherapy significantly improved survival. Distant metastasis did not alter prognosis. In patients managed surgically, R2 resection conferred a significant survival advantage and should be considered in all palliative patients with advanced disease when appropriate.

**0163: STAGE MIGRATION IN CURATIVE COLORECTAL CANCER RESECTIONS**


**Introduction:** The NHS Bowel Cancer Screening Programme introduced in 2006 aimed at detecting pre-malignant colorectal disease in patients aged >60 years. We assessed its impact on Dukes Stage presentation in patients undergoing curative colorectal resections.

**Method:** All patients undergoing curative resection between 2008 and 2012 were identified from a prospective database. Age at diagnosis and histological Duke’s Stage were analysed.

**Results:** 467 patients were identified (median age 69, male: female ratio 1:5:7:1). Total number of curative resections ranged from 111-123 (mean 117). Dukes A cancers significantly decreased from 32.2% in 2008 to 15.3% in 2012 (p=0.0024 chi-square test). Dukes B cancers rose from 26.3% to 38% in the same time period (p=0.05 Chi-square test). Dukes C cancers increased by 4.9%, however this did not attain statistical significance (p=0.516 chi-square test).

**Conclusions:** Following BCSP introduction, Dukes A cancers have decreased with a rise in Dukes B and C cancers in our cohort. The total number of annual curative resections remains unchanged. Stage migration to more advanced disease in curative resections may be attributable to more aggressive endoscopic treatment of premalignant adenomatous and Dukes A disease. Evaluation of stage migration in larger cohorts is needed, which may necessitate screening in younger patients.

**0170: MEDICAL NEGLIGENCE CLAIMS AND COLORECTAL MALIGNANCY IN THE NHS**

Georgios Markides l,2, Chris Newman l,2, 1 Huddersfield Royal Infirmary, Huddersfield, UK; 2 Airedale General Hospital, Keighley, UK.

**Background:** NHS clinical negligence claims and associated compensations are constantly rising. Our aim was to identify the magnitude, trends and causes of malpractice claims in relation to a common pathology such as colorectal cancer (CRC) in the NHS.

**Methods:** Data submitted to the NHS Litigation Authority from April 2003 to April 2012 in relation to CRC was acquired. This was subsequently reviewed, categorised clinically and analysed.

**Results:** 169 claims were identified, of which 123 (73%) cases had been closed. 80 (56%) of these claims were successful. An increasing overall claim frequency and success rate has been recorded over the last few years. Total litigation expenses were £8.6 million out of which 39% were paid out as legal expenses. The commonest cause of complaint in successful claims was in relation to diagnostic delays or failures (58%, £5.1 million), with a delay or failure by the clinician to take action in response to an abnormal investigation result being a major factor. The occurrence of peri-operative complications (20%, £1.6 million) was the second commonest cause.

**Conclusion:** Average frequency and success rates of “CRC” related malpractice claims in secondary care in the NHS are rising. Diagnostic failures and/or delays are significant contributing factors.

**0171: FLEXIBLE SIGMOIDOSCOPY ALONE FOR RIGHT SIDED COLON CANCER WITH COLORECTAL SYMPTOMS**

Kamran Khatri, Ladwa Nikhil, Baig M.K, McFall Malcolm, Pauline Whitehouse. Western Sussex Hospitals NHS Trust, Worthing, UK.

**Aims:** The objective of this study is to identify all the right sided colon cancers (including splenic flexure), which may have been missed if flexible sigmoidoscopy alone is used as a sole investigation.

**Methods:** All right sided colon cancers from January 2010 to June 2012 were identified through a prospectively collected regional cancer database.

**Results:** One hundred and ninety patients were identified with mean age of 63 (32 - 94) years. Thirty-three patients were admitted with bowel obstruction (22) and through BCSP (11) and were excluded. One hundred and twenty-eight patients underwent right colonic resection. Of the remaining 158 patients, 147 patients presented with either IDA or abdominal mass or both. Eleven patients were diagnosed with right sided colon cancer presenting with symptoms of altered bowel habits, rectal bleeding or/and abdominal pain without IDA or abdominal mass.

**Conclusion:** Approximately 7% (11/158) colonic cancer would have been missed over 30 months, if these patients had undergone flexible sigmoidoscopy alone. Patients undergoing flexible sigmoidoscopy alone to investigate lower GI symptoms should be informed regarding this possible miss rate.

**0172: THE VALUE OF ANORECTAL INVESTIGATIONS IN PREDICTING PATIENT OUTCOME AFTER BIOFEEDBACK TREATMENT FOR MANAGEMENT OF FAECAL INCONTINENCE**


**Aim:** Identify predictors of patient outcome after a course of biofeedback for management of Faecal Incontinence (FI).

**Methods:** Retrospective analysis of prospectively collected data was performed on 137 consecutive patients that underwent biofeedback between January 2007 – June 2012. Data was collected on patient demographics, baseline incontinence scores, anorectal manometry, rectal sensitivity studies and endoanal ultrasound reports. After performing univariate analysis data was entered in a logistic regression analysis model in order to identify independent predictors of the outcome.

**Results:** 137 patients (123 female) with a median Wexner score 12 (range 5-20) prior to biofeedback were identified. 95/137 (69%) responded favourably to biofeedback (‘responders’). Univariate analysis showed that the following variables differed significantly (p<0.05) between ‘responders’ and ‘non-responders’: age, duration of symptoms, severity of FI, mean maximum squeeze and resting anal pressure. However, after entering the data in a logistic regression model, age, duration and severity of incontinence were the only independent predictors of patients’ response to biofeedback.

**Conclusion:** Younger age, shorter duration of symptoms and lower FI scores were independent predictors of favourable patient outcome after biofeedback. These variables could therefore be used to aid patient selection. Anorectal manometry /electrophysiology have limited value in identifying patients that would benefit from biofeedback.

**0198: SURGICAL SEPSIS AND DELAYS IN SOCIAL SERVICES AND INTERVENTION SERVICES ACCOUNT FOR PROLONGED HOSPITAL LENGTH OF STAY IN GENERAL AND COLORECTAL SURGERY**

Carl Rotee, Eastbourne District General Hospital, Eastbourne, UK.

**Background:** Current economical climate challenges have enforced service reconfiguration, which is now being implemented across the NHS. Cost saving methods are being implemented in order to overcome a £20 billion deficit. Addressing factors which influence length of hospital stay (LOS) in the surgical patient journey may save costs.

**Methods:** General and colorectal surgical patients admitted within a 30d period to Eastbourne DGH for emergency and elective procedures were audited. Corrected LOS was determined by subtracting absolute LOS from an average expected LOS for procedure type. Causes for increased LOS were identified. Annual cost for prolonged LOS was calculated. Mann-Whitney test was used to assess significant differences in age between factors.
Results: 16 of 183 (8.7%) patients had increased LOS. Mean age was 74 y (SD=15y). Total LOS for the cohort was 366d (mean LOS 224, SD±20d) and corrected LOS was 245d (mean 15.4d, SD±18.8d). Surgical Sepsis accounted for 143d, social service delays for 83d and intervention services delays for 18d. There was no significant difference for age between factors. Overall estimated annual extra bed cost was £661500.

Conclusion: Incidence of surgical sepsis and the efficiency of intervention services and social services should be targeted to reduce prolonged surgical LOS.

Aim: Fluid and electrolyte management for patients with high output stomas/enterocutaneous fistulae is challenging. Historically, their care required repeated admissions to avoid ongoing complications eg, acute renal failure. We report our experience of outpatient management of such patients led by a nutrition support team.
Method: A retrospective analysis of a prospectively maintained database was performed. All patients met their nutrition needs enterally. Patients attend a ward based clinic with facilities for monitoring (weight, fluid balance, diet, PICC line care, bloods, urinary sodium and medication review) and IV hydration and/or magnesium/potassium supplementation. Individual cases are discussed at a weekly nutrition support team meeting.
Results: Between September 2009 - September 2012, 83 patients attended (male:female 43:40, median age 66, range 18-92). 73 had high output stomas, 11 had enterocutaneous fistulas. Total clinic days attended was 1239 (median 9 range 1-109 days). On 224 visits, IV fluids were administered, of which 95 were given IV magnesium and three, IV potassium. Eleven required admission (admission rate 1%). Other outcomes were either optimisation for surgery, discharge without surgery or long term monitoring without inpatient stay.
Conclusion: Patients with complex fluid balance and electrolyte needs can be managed successfully in the outpatient setting.

Aim: To compare oncological outcomes and cost of laparoscopic and open surgery for right hemicolecotomy.
Methods: Patients who had a right hemicolecotomy from January to November 2011 were identified from a prospectively maintained database of operations. Oncological outcomes were recorded and costs of surgery were calculated by costing each item of equipment used for each case.
Results: There were 44 patients (28 men (64%); median age 72.8 years (range, 18.4-89.2)). Thirty-two patients (73%) had elective surgery. Thirty patients (68%) had a laparoscopic operation (3 converted). Of the 17 open cases, 8 (47%) were acute cases as compared to 4 emergency cases out of 27 laparoscopic cases (15%, P=0.019). Primary pathology was cancer in 37 patients (84%). There were no differences between laparoscopic and open surgical in surgery in time (181 minutes vs. 134 minutes [open], P=0.593), resected nodes (16 vs. 16, P=0.968), distance to nearest longitudinal margin (65 cms vs. 75 cms, P=0.078) or inpatient stay (7 vs. 8, P=0.681). Laparoscopic surgery was significantly more expensive (£1014 vs. £439, P=0.032).
Conclusions: Laparoscopic surgery for right hemicolecotomy is associated with equivalent oncological adequacy but is considerably more expensive than open surgery. This may be important in healthcare planning with future financial constraints.

Aims: Iron-deficiency is common following colorectal cancer (CRC) resection. For those who require adjuvant chemotherapy, pre-existing anaemia increases the risk of requiring blood transfusion. We aimed to assess current provisions of post-operative oral iron supplementation (Fe²⁺).
Methods: In 2011, we undertook a single-centre retrospective study of patients undergoing potentially-curative CRC resections. Demographic, haematological, histological and therapeutic data was retrieved. Follow-up haematological data was obtained for a cohort of patients who re-attended for adjuvant chemotherapy.
Results: 118 patients were identified, 61 patients were anaemic on admission and 83 on discharge, of whom 46 had Hb <10g/dL. Seven (8%) of the anaemic patients had Fe²⁺ prescribed at discharge. 32 patients received adjuvant chemotherapy, of these 24 (75%) were anaemic at discharge of whom 16 (67%) remained anaemic at the start of chemotherapy. The mean haemoglobin rise between discharge and commencing chemotherapy was 2.1g/dL (SD 0.57) with Fe²⁺ versus 1.6g/dL (SD 1.33) without. Three patients, all with untreated anaemia required blood transfusion during chemotherapy.
Conclusions: A majority of patients are anaemic following resectional surgery for CRC. Treatment at discharge was inadequate at the study centre. Fe²⁺ may improve restoration of normal haemoglobin prior to adjuvant chemotherapy with the potential to reduce transfusion requirement.

Aims: To assess the effect of IV Hyoscine butylbromide (Buscopan) on luminal distension for CT virtual colonoscopy (CTVC).
Methods: Over 4 months patients were randomly selected and given 20mg of Buscopan intravenously before undergoing CTVC. These scans were compared to a set of randomly selected control scans where Buscopan had not been administered. Using the same grading system as Taylor et al, a G1 radiology consultant graded all of the images. The colon was divided into 6 segments (Caeum, Ascending, Transverse, Descending, Sigmoid, Rectum) and each was graded from 0 (collapsed colon) to 3 (excellent distension, folds <2mm) in supine and prone positions.
Results: There were 46 patients in total (23 per group). The Buscopan group showed improved distension in all segments of colon. There was a 50% increase in the number of 3’s scored in the ascending and descending colon images, 30% for transverse and 20% for rectum and sigmoid. Caeal imaging had a high rate of 3 scores in both groups. Overall 86% of Buscopan images scored 3 compared to 54% of non-Buscopan.
Conclusions: The use of IV Buscopan improves colonic distension for CTVC providing better imaging. This may help avoid repeat investigations.