trust therefore only an additional cost of £10,000 per year would be required for a dedicated anaesthetist.

0383: ARE THE NUMBER OF LYMPH NODES EXCISED DURING AXILLARY NODE CLEARANCE SURGERY AFFECTED BY NEOADJUVANT CHEMOTHERAPY?

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Introduction: Neoadjuvant chemotherapy may change the macroscopic architecture of lymph nodes (LNs) to such a degree that the number counted by a histologist following axillary node clearance (ANC) is lower than expected by the surgeon. We test the hypothesis that chemotherapy prior to ANC reduces the number of LNs.

Methods: Retrospective study examining records for all patients undergoing ANC at a NHS Trust over a 17 month period. We compared the number of LNs counted on histological examination between the patient groups who had received neoadjuvant chemotherapy and those who had not, with further subdivision into groups who had undergone sentinel node biopsy (SNB) prior to ANC and those who had not.

Results: There were 237 ANC operations including 98 ANC alone, 36 ANC following chemotherapy but no SNB, 61 ANC following SNB but no chemotherapy, and 42 following both SNB and chemotherapy, yielding 14.4 (±6.5), 13.0 (±5.8), 14.3 (±5.1), and 15.1 (±5.5) mean LNs respectively ($p = 0.398$).

Conclusion: We find no statistically significant difference in the number of LNs from excised axillary tissues between patients who received neoadjuvant chemotherapy and those who had not. Lower than expected number of LNs may not credibly be attributed to neoadjuvant chemotherapy.

0387: BLUE DYE DIRECTED AXILLARY NODE SAMPLING- REVISING THE ROLE

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Aim: To evaluate whether combination of Sentinel Lymph Node Biopsy (SLNB) using patent blue dye and four node sampling as a reasonable alternative to SLNB (dual technique), in early breast cancer as guidelines recommend.

Methods: A retrospective study of SLNB using patent blue dye and four nodes sampling performed by a single surgeon from 2006–11. All 245 patients treated by WLE were included. SLN were localised by injecting 2 ml patent blue dye in the subareolar with further level 1 sampling done to achieve a minimum of 4 nodes, by palpation. Node positive axillae were treated by radiotherapy or clearance as per MDT decision.

Results: The detection rate was 97.95% (240/245 patients). 41 patients had only one node involved in their axilla. Axillary positive axillae were counted by a histologist following axillary node clearance (ANC) is lower than expected by the surgeon. We test the hypothesis that chemotherapy prior to ANC reduces the number of LNs.

Conclusion: We find no statistically significant difference in the number of LNs from excised axillary tissues between patients who received neoadjuvant chemotherapy and those who had not. Lower than expected number of LNs may not credibly be attributed to neoadjuvant chemotherapy.

0384: DIFFERENCES IN PATIENT EXPERIENCE AND UNDERSTANDING OF CONSENT WHEN CARRIED OUT IN CLINIC AND ON THE DAY OF SURGERY

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Aims: To assess patients' subjective perception of consent and recall of information when comparing those consented in clinic with those consented immediately before surgery.

Methods: Prospective study of patients undergoing breast and general surgical operations. Patients were randomised to consent in clinic or consent immediately before surgery. Patients completed a post-operative questionnaire assessing satisfaction and recall of complications using a tick-box list of 16 common complications, 6 of which were correct for each operation. An overall score of correct minus incorrect answers was calculated out of 6.

Results: 27 patients were included, 17 consented immediately pre-operatively, and 10 in clinic (mean ~ 13 days pre-op). The mean overall score for recollection of complications was 3 when consented on the day and 2.9 when consented in clinic. Subjective ratings of experience were not significantly different between the groups. Overall recall rates were better for general complications (96% bleeding, 100% infection and 74% anaesthetic risk) than specific risks (25% seroma in breast patients).

Conclusions: In our experience patients can be consented either in clinic or on the day of operation as there is no difference in their subjective perceptions of complication recall. However only small numbers have been assessed so far.

0457: IS MAMMOGRAM AN ESSENTIAL INVESTIGATION FOR DETECTING BREAST CANCER IN PATIENTS YOUNGER THAN 40 YEARS?

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Aims: Breast cancer is the commonest female cancer diagnosed in the UK. In November 2010, the ‘Best Practice Diagnostic Guidelines for Patients Presenting with Breast Symptoms’ were amended. This study aims to evaluate the safety of the proposed changes that state mammography is no longer an essential first line investigation for women under the age of 40, with breast symptoms.

Methods: A retrospective cohort study of 40 patients, from January 2007 to July 2011, with histologically confirmed breast cancer diagnosed when under the age of 40 was performed by comparing mammography and ultrasound results.

Results: All patients presented with a symptomatic lump and underwent ultrasound scanning, mammography and core biopsy. No patient with a normal ultrasound was found to have an abnormal mammogram. In all 40 patients ultrasound scanning showed 100% sensitivity in identifying the breast lesions with 95% identified as indeterminate, suspicious or malignant radiologically.

Conclusions: The new symptomatic breast guidelines are safe to implement, as ultrasound is an adequate first line investigation. If any suspicious ultrasound abnormality is detected then mammogram is essential for further assessment as this could demonstrate further pathological changes which may affect clinical management. This should lead to improved patient care and resource management.

0471: BREAST PAIN UNDER THE AGE OF 50: IS MAMMOGRAPHY REALLY NECESSARY?

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Aim: The aim of this study was to assess whether routine mammography in patients presenting with painful breasts, and no palpable mass is necessary in those under the age of 50 years.