questionnaire was administered at follow up. The median follow up period was 209.5 days.

**Results:** 85% of those responding had returned to sport, with 50% making a full return to their previous standard. The mean improvement in Oxford Score following surgery was 12.3. The improvement in Oxford Score, age and gender had an influence on return to sport.

**Conclusions:** Return to sport is a useful outcome measure, but not in isolation. Athletes wishing to return to sport following shoulder stabilisation can expect good outcomes provided they comply with the rehabilitation protocol. Psychology plays a large role in a patient’s decision to return to sport.

**0274: A COMPARISON OF CONSENT: PROXIMAL FEMUR FRACTURES VERSUS ELECTIVE TOTAL HIP REPLACEMENT**

Simon Humphry, Efstratios Gerakopoulos. Gloucestershire Royal Hospital, Gloucester, UK

**Aims:** To compare consent documentation for patients having surgery for proximal femur fractures (PFFs) versus elective patients undergoing total hip replacement (THR).

**Methods:** Concurrent audits over a 28-day period of consent forms for adult patients (with capacity) undergoing surgery for PFFs and elective THR within the same department. Standards based on British Orthopaedic Association (BOA) endorsed ‘Orthoconsent’ website guidelines, modified following departmental consultant survey.

**Results:** PFFs: n = 24. Consenter grade: consultant = 0%, middle grade = 8%, SHO = 92% nurse = 0%. Consenter operating = 13%. Sticker/stamp on consent form: 0%. Proportion of risks/complications documented: 56%. Information provided: 0%. Elective THR: n = 50. Consenter grade: consultant = 28% middle grade = 30%, SHO = 4% nurse = 38%. Consenter operating = 62%. Sticker/stamp on consent form: 78%. Proportion of risks/complications documented: 76%. Information provided: 58%.

**Conclusions:** Senior doctors and specialist nurses take consent for the majority of elective THRs, with better documentation of risks/complications and improved provision of information. In contrast, consent for patients undergoing surgery for PFFs is mainly obtained by ward-based junior doctors. The role of stickers/stamps appears beneficial, although this audit suggests an update is needed, in accordance with the BOA endorsed guidelines. Although the study numbers are low, it demonstrates the need for further research into consenting practices and better training/support for junior doctors.

**0275: IMPROVING CONSENT IN PATIENTS UNDERGOING SURGERY FOR PROXIMAL FEMUR FRACTURES THROUGH THE INTRODUCTION OF ‘CONSENT CARDS’ FOR JUNIOR DOCTORS**

Simon Humphry, Efstratios Gerakopoulos. Gloucestershire Royal Hospital, Gloucester, UK

**Aims:** To audit the consent for risks/complications in patients undergoing surgery for proximal femur fractures (PFFs) versus elective patients undergoing total hip replacement (THR).

**Methods:** Initial audit over a 28-day period of consent forms for adult patients (with capacity) undergoing surgery for PFFs and elective THR. Follow-up audit over a 28-day period of consent forms for adult patients (with capacity) undergoing surgery for PFFs and elective THR. Standards based on British Orthopaedic Association (BOA) endorsed ‘Orthoconsent’ website guidelines, modified following departmental consultant survey.

**Results:** PFFs: n = 24. Consenter grade: consultant = 0%, middle grade = 8%, SHO = 92% nurse = 0%. Consenter operating = 13%. Sticker/stamp on consent form: 0%. Proportion of risks/complications documented: 56%. Information provided: 0%. Elective THR: n = 50. Consenter grade: consultant = 28% middle grade = 30%, SHO = 4% nurse = 38%. Consenter operating = 62%. Sticker/stamp on consent form: 78%. Proportion of risks/complications documented: 76%. Information provided: 58%.

**Conclusions:** Senior doctors and specialist nurses take consent for the majority of elective THRs, with better documentation of risks/complications and improved provision of information. In contrast, consent for patients undergoing surgery for PFFs is mainly obtained by ward-based junior doctors. The role of stickers/stamps appears beneficial, although this audit suggests an update is needed, in accordance with the BOA endorsed guidelines. Although the study numbers are low, it demonstrates the need for further research into consenting practices and better training/support for junior doctors.

**0280: ORTHOPAEDIC SURGEONS’ PERCEPTION OF INTRAOPERATIVE BLOOD LOSS**

Basil Budair, Taiceer Abdul-Wahab, Tim McBride, Mujeeb Ashraf. University Hospital Birmingham NHS Foundation Trust, Birmingham, UK

**Introduction:** One of the questions on the WHO checklist to surgeons is: what is the anticipated blood loss? We feel that orthopaedic surgeons are poor at estimating peri-operative blood loss.

**Aim:** To assess the accuracy of orthopaedic surgeons’ perceptions of intra-operative blood loss, both pre and post operatively.

**Methods:** Patients undergoing hip fracture surgery from April to December 2011. Registrars were asked pre and post operatively what they expected the blood loss to be. Actual loss was calculated based on the amount of blood retrieved in both swabs and the suction.

**Results:** 55 patients undergoing hip fracture surgery were included. The mean pre op estimated value was 260ml and mean actual value was 465ml (P value = 0.01). In 44 (80%) patients blood loss was underestimated. The mean difference between pre op estimation and actual loss was 205ml i.e. almost 80% difference! Mean pre op estimate was 260ml and mean post op estimate 270ml (not significantly different).

**Conclusion:** Orthopaedic surgeons are poor at estimating blood loss. Answers to the WHO checklist question posed could be misleading and therefore pose a clinical risk. We propose the question be changed to: - Are you expecting excessive blood loss? Yes / No.

**0401: THE PORTRAYAL OF BACK PAIN IN THE UK PRESS**

Clarissa Cheah, William James Nash, Mohamed Musa, Arash Danesh, Andrew Harris, Shafic Said Al-Nammari. Princess Alexandra Hospital, Harlow, UK

**Method:** National newspaper articles were retrieved from LexisNexisTM Professional over 6 months (May 2009- October 2009), using the terms “back pain/ backpain/ back ache/ backache".

**Results:** 284 articles were collected. 62% were from tabloids and 38% from broadsheets. 15% of articles were case reports. Back pain was mentioned in passing in 75% of all articles. It was the main topic in 18% and the sole topic in 7% of papers. The causes of back pain were mentioned in 11% of articles. Non-surgical treatment was more likely to be mentioned. (Fishers’ Exact test p = 0.01). 10% of papers included a quote from an “expert”. Overall, 98% of articles portrayed a neutral tone, with 1% positive or negative. Articles concerning physiotherapists or new surgical techniques were significantly more likely to show a positive overall tone. (Fishers’ Exact Test p = 0.04).

**Conclusion:** The aetiology of back pain is poorly represented and quoted “experts” are frequently from non-medical personnel. New surgical treatments receive significantly less attention than new non-surgical treatments. We need to engage with the press and positively influence their reportage of back pain.

**0404: SYMPTOM LENGTH, DOMINANCE AND GENDER DO NOT AFFECT RATE OF PROGRESSION TO SURGICAL DECOMPRESSION IN PATIENTS WITH CARPAL TUNNEL SYNDROME**

Nicholas Gill, Munier Hossein, Mel Jones, Yshbyt Gwyntedd, Bangor, UK

**Aims:** To assess predictive factors in progression to surgical decompression following steroid injection in Carpal Tunnel Syndrome.

**Methods:** Retrospective data analysis from patients who received steroid injections for Carpal Tunnel Syndrome over a 2 year period with a minimum 1 year follow up.

**Results:** 59 patients had 79 Carpal Tunnels injected over 2 years. 35 patients chose surgery following steroid injection (59%), with 24 patients not progressing to surgery (41%). In the group that underwent surgery, the mean length of symptoms was 35.3 months (range 4-180) with 19 patients (56%) having symptoms for greater than 2 years. In the non surgical group the mean length of symptoms was 42.9 months (range 3-180) with 14 of the patients (56%) having symptoms for greater than 2 years. In the non surgical group the mean length of symptoms was 42.9 months (range 3-180) with 14 of the patients (56%) having symptoms for greater than 2 years.

**Conclusions:** Symptom progression was not influenced by either duration or laterality.

**0443: FACTORS AFFECTING THE DECISION TO UNDERGO SURGERY FOR A SLIP DISK MISHAP**

Said Al-Nammari, Ashraf Danesh, Simon Humphry, Efstratios Gerakopoulos. Gloucestershire Royal Hospital, Gloucester, UK

**Aims:** To audit the consent for risks/complications in patients undergoing surgery for proximal femur fractures (PFFs) versus elective patients undergoing total hip replacement (THR).

**Methods:** Concurrent audits over a 28-day period of consent forms for adult patients (with capacity) undergoing surgery for PFFs and elective THR within the same department. Standards based on British Orthopaedic Association (BOA) endorsed ‘Orthoconsent’ website guidelines, modified following departmental consultant survey.

**Results:** PFFs: n = 24. Consenter grade: consultant = 0%, middle grade = 8%, SHO = 92% nurse = 0%. Consenter operating = 13%. Sticker/stamp on consent form: 0%. Proportion of risks/complications documented: 56%. Information provided: 0%. Elective THR: n = 50. Consenter grade: consultant = 28% middle grade = 30%, SHO = 4% nurse = 38%. Consenter operating = 62%. Sticker/stamp on consent form: 78%. Proportion of risks/complications documented: 76%. Information provided: 58%.

**Conclusions:** Senior doctors and specialist nurses take consent for the majority of elective THRs, with better documentation of risks/complications and improved provision of information. In contrast, consent for patients undergoing surgery for PFFs is mainly obtained by ward-based junior doctors. The role of stickers/stamps appears beneficial, although this audit suggests an update is needed, in accordance with the BOA endorsed guidelines. Although the study numbers are low, it demonstrates the need for further research into consenting practices and better training/support for junior doctors.