C.Y.Y. Wong 1,*, A. Shakir 1, A. Farboud 2, H. Whittet 1. 1 Morriston Hospital, Swansea, UK; 2 University Hospital Wales, Cardiff, UK.

Background: Artificial humidification should be provided in the post-operatively for self-venting tracheostomy and laryngectomy patients to prevent pulmonary complications. Heated humidification and heat and moisture exhanger are common humidification options for these patients, however the optimal method of humidification is not known.

Objective: To determine whether active or passive humidification methods are more effective in preventing pulmonary complications in self-ventilating neck breather patients

Method: We included all studies of active and passive humidification techniques in adult and paediatric neck breather patients. Risk of bias was assessed using Cochrane Risk of Bias Tool for RCTs and STROBE guidelines for cross-over, prospective, and retrospective studies.

Result: Seven studies were included in this review: two randomised control trials, one randomised controlled cross over trial, three randomised prospective studies, and one retrospective study. The overall quality of the studies was low. Five studies were at a high risk of bias. Of the remaining two studies, one study had a low risk of bias and the other had an unclear risk.

Conclusion: Results show that heat and moisture exhangers is the preferred choice of humidification in the spontaneously breathing neck breathers due to reduction of pulmonary complaints, and better patient compliance.

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0831: A REVIEW OF THE MANAGEMENT OF ACUTE MASTOIDITIS IN CHILDREN. EXPERIENCE FROM UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST, A TERTIARY TEACHING CENTRE


Aim: To review the clinical presentation, management and outcome of acute mastoiditis in children. This study also presents an algorithmic approach to its treatment.

Method: The medical records of all children admitted with acute mastoiditis between 2010 and 2015 were retrospectively studied.

Result: 33 patients were included, 39% were male and 61% female. All patients were admitted and received intravenous antibiotics, 45% (15/33) underwent surgery. Surgery was performed if there were no signs of improvement after 24 hours of conservative treatment or the patient presented with a mastoid abscess or intracranial complication on admission. Imaging was obtained in only 46% (7/15) of patients before surgery. Of those treated surgically, incision and drainage +/- grommet insertion was performed in 60% of patients and cortical mastoidectomy in only 40%. There was no statistical difference in length of stay, complication or readmission rates between these modalities. A strong positive correlation was seen between delay in surgery and total hospital stay (R = 0.72, p = 0.004).

Conclusion: To minimise duration of unresolved mastoiditis and risk of secondary complication, surgery should be considered in patients who fail to improve after 24 hours of intravenous antibiotics. We observed no difference in outcome between incision and drainage and cortical mastoidectomy.

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0997: COMPLETION PAROTIDECTOMY: A DGH EXPERIENCE – HOW DO WE COMPARE?

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Aim: To assess morbidity associated with return to theatre for completion parotidectomy compared with primary total parotidectomy.

To assess the sensitivity and specificity of our FNA results compared to fixed formalin tissue histology.

Method: Retrospective review of all parotidectomies (superficial, total and completion) at Royal Glamorgan Hospital were analysed between March 2010 and September 2015.

Result: 115 patients.

FNA results suggested: malignancy in 26.1% benign in 51.3% unclear in 19.1% 3.0% did not have an FNA. Permanent facial weakness following completion parotidectomy was present in 80% of our patients, 40% had grade IV and above. Only 2% of those that had primary total parotidectomy had permanent facial weakness.

Conclusion: Reported parotid FNA sensitivity is 88% and specificity is 99%. Our FNA rates show a sensitivity 69% and a specificity 93%, however this was a selected population of theatre cases. Only 4.3% of patients required return to theatre for completion surgery. Our false negative rate was 10%, comparing favourably with nationally reported rates of 16.3%. Our malignancy rate is higher at 34.8% than published rates. Primary total parotidectomy gives more favourable facial nerve outcomes than completion parotidectomy. Possible strategies to increase early diagnosis should be considered.

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1110: A LOGO SAVES A THOUSAND WORDS. A RIGOROUS MULTI-SECTOR ENT QUALITY IMPROVEMENT PROJECT FOR PATIENT SAFETY

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Introduction: Our ENT referral unit received a patient with a Rapid-Rhino® nasal tampon device inserted without removal of its protective blue sheath. This exact issue was raised in a recent RCS publication.

Training and induction are often advocated for medical devices but this incurs time and cost for every junior doctor rotation.

Method: We contacted Smith & Nephew(S&N) (manufacturers). We identified an opportunity to prevent further morbidity.

Write “Remove this” on the blue sheath. We think this is a simple and necessary modification to the existing product.

Result: S&N were contacted by phone, email and in-person but could not successfully perform a ‘root-cause-analysis’. They delivered training locally but shifts and staff constantly rotate and the use of medical devices by untrained staff may escalate.

Multiple language requirements were cited as a barrier to altering packaging. Undaunted we contacted local arts universities to set them the challenge.

Conclusion: The University of Creative Arts’ MA Illustration students each created a selection of word-less logos to indicate that the blue sheath must be removed. (Designs pictured). We implore ASIT, the Royal College and the Medicines and Healthcare Regulatory Agency to consider our message and advocate the adoption of our logo.

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1124: EMERGENCY CARE RECOGNITION AND MANAGEMENT OF BUTTON BATTERY INGESTION: A REGIONAL PERSPECTIVE

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Introduction: Button battery ingestion accounts for under 2% of ingested foreign bodies in children[1] Localised tissue burns may result in catastrophic haemorrhage or airway compromise, with mucosal damage occurring in under 2.5hours[2]. The significant risk of death and serious harm from delays in recognition and management, led to the issue of a patient safety alert by NHS England (December 2014). We aimed to assess