determine the necessity of post-procedure imaging, and in turn formulate local guidelines. 

**Method:** All consecutive Hickman lines inserted in our hospital between June 2006 and December 2010 were studied. Data was collected using a standardised proforma and details like vein used, peri-operative imaging, position of catheter tip and complications were noted.

**Results:** 147 Hickman lines were inserted during the study period. 102 procedures were done by surgeons and 45 by radiologists. The subclavian route was the preferred approach in 68.7% cases. Of those inserted in theatre, 100 were under radiological guidance, of which 90 had a post procedure chest radiograph. Radiologists used image-guidance for all 45 patients, with only 11% having a post-procedure radiograph. Out of all 97 post-procedure radiographs there were no reported complications.

**Conclusions:** We recommend that following the placement of a Hickman line under radiological guidance, there is no requirement to perform a chest radiograph. This will inevitably save hospital resources but also reduce radiation exposure to the patient.

**0734 A NOVEL IMPLEMENTATION TO FIX NECK OF FEMUR FRACTURES WITHIN 48 HOURS**

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**Aims:** British Orthopaedic Association guidelines aim to treat 75% of neck of femurs fractures (NOFF), in otherwise medically fit patients, within 48hrs of arriving to hospital. Further to this the Department of Health introduced a 5% bonus fee for treating NOFF by 36 hours. Could these targets be better achieved with introducing dedicated ‘NOFF’ trauma lists?

**Methods:** We conducted a retrospective audit of NOFF patients from 6th Aug 2008 to 9th Nov 2008, and prospectively audited those admitted 1st Feb 2009 to 1st May 2009, after institution of extra NOFF trauma lists. The loop was closed by a prospective audit from, 2nd July 2009 to 30th Oct 2009 to assess the impact of reducing these trauma lists.

**Results:** 389 NOFF patients were reviewed with a median age of 83 (61-103). The introduction of three ‘NOFF’ lists a week in the RBH improved it's percentage of patients treated by 48hrs from 69.3% to 89.4%. As the NOF lists were reduced only 80.2% were treated in 48hrs, and 29.7% fewer patients were treated in less than 36hrs, which would translate to an annual loss of around £17,000 in bonus payments.

**Conclusions:** Thrice weekly dedicated NOFF trauma lists improve patient care and are financially beneficial.

**0735 LIVER RESECTION FOR NON COLORECTAL LIVER METASTASES – IS THERE A ROLE?**

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**Aims:** Liver resection for colorectal liver metastases is well established. There is evidence supporting resection in patients with non-colorectal primary tumours but no randomised controlled trials. We analysed resections performed for non-colorectal, non-neuroendocrine primaries.

**Methods:** We retrieved casenotes for patients referred for possible liver resection between 2002 and 2010. We analysed patient demographics, tumour characteristics, treatment offered and outcomes.

**Results:** We identified 24 patients referred with non-colorectal liver metastases (NCRLM). 19 patients underwent liver resection, 5 were not considered for surgery in view of disseminated disease. 11 men and 8 women underwent resection with a median age of 60 years (interquartile range 48 to 63). The primary tumours were ocular melanoma (5), renal cell (3), GIST (2), testicular (2), salivary gland (2), thymic (1), breast (1) duodenal adenocarcinoma (1), prostate (1) and ovarian (1). Median survival was 16 months (interquartile range 6-34 months). Interval between diagnosis of primary tumour and detection of liver metastases was longer in patients with resectable disease (11-177 months) compared with those who did not (0-24 months).

**Conclusions:** There is increasing recognition of the role of liver resection in NCRLM. Our experience supports current literature which suggests outcomes are improved by surgery in carefully selected patients.

**0737 ENDOSCOPIC NASAL POLYPECTOMY UNDER LOCAL ANAESTHETIC: THE PATIENT’S PERSPECTIVE**

Richard Green, Naveed Kara, Kate Blackmore, Richard Hogg, Cumberland Infirmary, Carlisle, UK

**Aim:** Assessing patient satisfaction with local anaesthetic endoscopic nasal polypectomy

**Method:** A 16-point questionnaire was sent to all patients who underwent the procedure over a two-year period. They were asked about previous operative history, quality of operative information given, level of pain felt and how well it was managed, effectiveness of procedure on their symptoms and overall perception of the experience.

**Results:** Of 32 patients, response rate was 81%. Half of the patients had previously had nasal polypectomy under general anaesthetic. 94% percent felt their pain was dealt with appropriately, and 88% would have the procedure repeated if needed. All patients were discharged within 6 hours and 92% reported symptomatic improvement and were happy with procedure.

**Discussion:** One of the seven pillars of clinical governance is to encourage patient involvement and feedback, and addressing practice accordingly (1). With national patient reported outcome measures (PROMS) being at the forefront of recent discussions, we highlight our patients’ experiences. The Department of Health has proposed improving healthcare by maximising day-surgery (2), and in addition to allowing for significant cost savings, we demonstrate that effective use of local anaesthesia allows for the procedure to be carried out safely as day-case surgery.

**0738 MANAGEMENT AND OUTCOME PREDICTORS IN ACUTE SURGICAL ADMISSIONS FOR LOWER GASTROINTESTINAL BLEEDING**


**Aims:** Our aim was to elucidate factors which can be implemented for early risk stratification of patients presenting with lower gastrointestinal bleeding (LGB).

**Methods:** Patients identified from prospectively maintained surgical admissions database. Data collected on 26 clinical factors available on initial presentation. Severe bleeding defined: continued bleeding within first 24 hrs, requirement of blood transfusion, decrease in haematocrit >20%, recurrent bleeding >24 hrs of stability. Adverse outcome defined: emergency surgery to control bleeding, ITU admission, death.

**Results:** 172 patients with LGB, representing 3% of all surgical referrals. Severe bleeding occurred in 106 patients (61.6%). Adverse outcome recorded in 20 patients (11.6%); 10 patients (5.8%) died during admission. Commonest aetiologies: diverticulitis, haemorrhoids, and neoplasm. Three independent prognostic factors for severe bleed identified: haematocrit <0.35 (p<0.002), bright red blood per rectum on examination (p<0.001), and age >60 years (p=0.03). Four independent prognosticators of an adverse outcome were identified: creatinine >150 (p=0.002), age >60 years (p=0.001), abnormal haemodynamic parameters (p=0.05) and continued bleeding within the first 24 hours (p=0.05).

**Conclusions:** These independent prognostic factors may facilitate identification of patients who should be candidates for more aggressive resuscitation, admission to monitored bed and consideration for early surgical intervention.

**0739 OPERATIVE MANAGEMENT OF APPENDICULAR PHLEGMON – A FIVE YEAR NATURALISTIC FOLLOW-UP STUDY**

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**Background/Aim:** Acute appendicitis can often manifest with an appendicular mass. Although appendicectomy is often a life saving procedure especially in patients with perforated appendix and peritonitis, many...
studies show that appendicular mass and even perforated appendicitis can be managed conservatively. We investigated whether appendicectomy during the stage of mass formation carries any extra morbidity compared to surgery for non-mass forming appendicitis.

Patients and Methods: In hospital stay and post-operative complications of patients with intra-operative findings of appendicular phlegmon were compared with those not having appendicular mass over a period of 5 years.

Results: Between July 2004 to December 2009, 61 patients with appendicular mass and 363 patients with acute appendicitis / perforated appendicitis without appendicular mass were operated upon. Complications in appendicular mass group were wound infection (22.9%), wound dehiscence (9.83%) and incisional hernias (3.27%) while in the group without appendicular mass they were wound infection (7.1%) and wound dehiscence (3.03%). There was no mortality in either group.

Conclusion: Operating on patients with appendicular mass is safe, as it doesn’t entail any additional morbidity except for increased rate of wound infection and increased mean operating time, and is life saving in cases associated with perforation and peritonitis.

0740 IMPROVING THE QUALITY OF OPERATION NOTES IN GENERAL SURGERY
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Aim: Adequate documentation is a professional requirement, as stated in the RCSEng ‘Good Surgical Practice’ guide 2008. The NCEPOD 2009 (Death in Acute Hospitals: Caring to the end?) reported that poor documentation is commonplace in all aspects of management of surgical patients. We aimed to investigate whether operation note completion could be improved by displaying the RCSEng guidelines in the operating theatre.

Method: 72 operation notes were reviewed. 35 were reviewed prior to distribution of the RCSEng guidelines, 37 afterwards. Three assessors independently reviewed the notes and assessed them according to the guidelines.

Results: Prior to distribution of the guidelines, post-operative instructions were complete in 34%(12/35). Following the intervention, this improved to 97%(36/37), p<0.001. Only 77%(27/35) of notes in the first group were deemed sufficient to allow continuity of care, this subsequently increased to 97%(36/37), 0.001< p< 0.01 (Chi-Squared test).

Conclusions: Adequate completion of operation notes is essential for good clinical care. There is evidence of widespread deficiencies in this area with potential adverse implications. We have demonstrated that with a simple intervention the quality of operation notes can be significantly improved and suggest that teaching on completion of operation notes be included in surgical training.

0741 ONE YEAR AFTER THE ETWD: IMPACT ON TRAINEE OPERATIVE EXPERIENCE
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Aims: The EWTD limited junior doctor working hours to 48 hours per week from August 2009. This study assesses the impact of this legislation on the operative experience of general surgical trainees in one institution after one year.

Method: Data was obtained from a prospectively gathered operative database used to generate contemporaneous operation notes. Grade of operating surgeon and assistant(s) for all elective and emergency general and vascular surgical operations performed in July 2010 in our institution was recorded. A data set from July 2009 was obtained for comparison. Data was analysed using proportions and the chi-square test.

Results: There is no statistically significant reduction in trainees’ first operator experience. Trainees performed 43.4% of operations in July 2010 and 50.7% in July 2009 (p=0.03). There is a significant increase in trainees participating as assistants (p<0.01). Scrub practitioners are involved in a minority of procedures.

Conclusions: There is a trend towards reduced trainee operative experience after the introduction of the 48 hour week. Since August 2009, surgical trainees in our institution are not expected to attend out-patient clinics or endoscopy sessions to facilitate operative exposure. This may no longer be adequate to ensure acceptable levels of experience for safe surgical training.

0743 SENTINEL LYMPH NODE MICROMETASTASIS – SHOULD PATIENTS PROCEED TO AXILLARY LYMPH NODE CLEARANCE?
Abhilasha Patel, Mahmoud Dalka, Makam Kishore. George Eliot Hospitals NHS Trust, Nuneaton, UK

Aim: Sentinel lymph node biopsy offers a minimally invasive approach to the assessment of the axillary lymph node status in patients with breast cancer. Treatment of patients with a tumour deposit < 2mm (micrometastasis) remains controversial. The aim of this study was to determine if patients with micrometastasis should undergo axillary lymph node clearance.

Method: This is a retrospective review of all patients undergoing sentinel lymph node biopsy within our unit from June 2006 to December 2010. Sentinel node characteristics, tumour details and clinical outcome were recorded prospectively.

Results: 378 patients underwent sentinel lymph node biopsy (median age 60 years, range 28–83 yrs). 104/378 patients had a positive sentinel lymph node biopsy. 19/104 patients had evidence of micrometastasis. 17 patients with micrometastasis underwent axillary node clearance. Two patients were offered adjuvant therapy.

4/17 patients had positive axillary lymph nodes after the second procedure. There were no specific tumour characteristics predictive of non-sentinel lymph node metastasis in these patients.

Conclusion: Almost a quarter of patients with micrometastasis had evidence of further lymph node involvement. The presence of micrometastasis is a good predictor for non sentinel lymph node metastases and patients should undergo axillary clearance.

0746 END OF LIFE BLOOD TRANSFUSION IN PATIENTS WITH COLORECTAL CANCER – IS THERE A NEED FOR GUIDELINES?
Amanda McRead, Rachel Thomson, Pamela Paterson, Angus Macdonald. Monklands Hospital, North Lanarkshire, UK

Aims: While blood transfusion for incurable colorectal cancer patients may improve symptoms in patients with anaemia, stopping transfusion as part of withdrawal of active care is often considered. This presentation reports blood transfusion in the last four weeks of life.

Methods: Retrospective review of data on colorectal cancer patients was cross-referenced with the regional blood transfusion database. Information on patient age, sex, and curative/palliative management was collected. Group and save, cross-match and transfusion status in the 4 weeks leading up to death were noted.

Results: Between 1 January 2007 and 31 December 2008, 483 colorectal cancer patients were identified of whom 390 underwent surgery. At follow-up 31Dec 2010, 120 patients had died. Of these 76 had undergone prior curative resection and 44 conservative treatments. 10 patients in the curative surgery group and 5 in the conservative management group were transfused 4.5(2-20) units mean (range) within 4 weeks of death. Worrisomly 22 units were administered within 7 days of death and 10 units administered within 48 hours of death.

Conclusions: While overall transfusion rates in the later stages of care appeared acceptable, the appropriateness of transfusing patients with end stage disease in a palliative setting in whom other forms of active treatment has been withdrawn, is questionable.

0748 THE ROLE OF SPECIALIST NURSE CONSENTING IN CLINIC AND SURGERY EDUCATION IN REDUCING DAY-OF-SURGERY CONSENT RATES FOR ELECTIVE ENT SURGERY
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