**0884: HIGHER OPERATIVE MORTALITIES ARE ASSOCIATED WITH LAPAROTOMY, BOWEL RESECTION AND STOMA FORMATION IN EMERGENCY SURGICAL ADMISSIONS**

B. Ibrahim 1*, I. Ibrahim 1, D. Porter 2, M. Wilson 2, P. Patil 2, 1 University of Dundee, Dundee, UK; 2 NHS Tayside, Dundee, UK.

**Aim:** To determine operative mortality in our trust over different surgical cohorts.

**Method:** Analysis of mortality in emergency admissions between January 2008 and 2014. Categorised according to operative versus non-operative, laparotomy versus laparoscopic, small bowel and colonic resection versus nil and stoma versus no stoma.

**Result:** 40,389 emergency admissions to general surgery with an operative cohort of 8501 (21.0%). Of these, 1566 (18.4%) underwent a laparotomy versus 3302 (38.8%) laparoscopic procedures. A small bowel or colonic resection was performed in 1105 (13.0%) of the operative cohort. A stoma was formed during laparotomy in 441 (28.2%) cases. It was shown that emergency surgery necessitating laparotomy, small bowel or colonic resection and stoma formation is associated with the highest level of 30-day mortality (6.19%, 3.6% and 8.1% respectively) and 1-year mortality (16.1%, 12.1% and 25.4% respectively). Laparoscopic, no resection and no stoma surgeries had lower 30-day mortality rates (0.48%, 1.9% and 5.4% respectively) and 1-year mortality rates (1.9%, 5.2% and 12.9%).

**Conclusion:** Emergency surgery necessitating laparotomy, resection and stoma formation is associated with the highest levels of mortality at 30-days and 1-year. The above factors should be discussed with patient before obtaining consent. Further analysis is required on sepsis, age and neoplasm.

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**0913: IMPROVING THE CARE OF EMERGENCY LAPAROTOMY PATIENTS: MINIMISING DELAYS RELATED TO OBTAINING RADIOLOGICAL INVESTIGATIONS**

K. Waite 1, L.I. Lim, S. McAfee, S. Loganathan. Royal Albert Edward Infirmary, Wigan, UK.

**Aim:** Imaging is commonplace before emergency laparotomy. The EPOCH trial is developing peri-operative care pathways. Our aim was to assess performance against EPOCH’s standard for obtaining CT imaging (<2 hours of decision) and identify potential improvements.

**Method:** An audit of emergency laparotomy patients was performed by recording timings: admission, decision, scanning and reporting. The results were distributed via departmental meetings and email. Discussions with the radiology department were initiated. To assess for change, we repeated the audit.

**Result:** There were 18 and 23 patients in cycles 1 and 2 respectively. In cycle 1, the decision-to-scanning interval was <2 hours in 10/18 (55.56%) and <6 hours in 17/18 (94.44%), compared to <2 hours in 14/23 (60.86%) and <6 hours in 22/23 (95.65%) in cycle 2. In cycle 1, the decision-to-reporting interval was <2 hours in 4/18 (22.22%) and <6 hours in 17/18 (94.44%). In cycle 2, this was <2 hours in 3/23 (13.04%) and <6 hours in 18/23 (78.26%). The median decision-to-scanning and decision-to-reporting intervals improved from 101 and 212 minutes to 101 and 180 minutes respectively.

**Conclusion:** We demonstrated improvement following intervention. Further work is needed to minimise the delays. Developments in peri-operative care pathways will improve patient outcomes.

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**0921: OUTCOMES AFTER EMERGENCY LAPAROTOMY AT A SECONDARY LEVEL HOSPITAL IN RURAL ZAMBIA**

T. Hoskins 1*, E. Hoogakker 2*, R. Bleichrodt 2*. 1 Newcastle University Medical School, Newcastle, UK; 2 Saint Francis’ Hospital, Katete, Zambia.

**Introduction:** Prompt laparotomy can be life-saving but the procedure itself is inherently dangerous. These risks are amplified in a resource poor setting so this study aimed to explore the outcomes of emergency laparotomy at Saint Francis’ Hospital, Zambia.

**Method:** All patients who underwent emergency laparotomy for an acute abdomen at Saint Francis’ Hospital between February 2012 and December 2014 were included. A proforma was designed to gather data retrospectively using patient notes. The primary outcome measure was in-hospital mortality. Secondary outcomes were the incidence of in-hospital complications, classified using the Clavien-Dindo system, indication for surgery and cause of death.

**Result:** During the study period 239 patients underwent laparotomy for an acute surgical indication. In-hospital mortality was 12.6% (n=30) with the commonest cause recorded as ‘cardiopulmonary collapse’ (n=12) followed by sepsis (n=7). A further 70 patients survived in-hospital complications: grade 1 (n=32), grade 2 (n=29), grade 3 (n=9). No patients survived a grade 4 complication.

**Conclusion:** When compared with the incidence of other complications the mortality rate was high. The absence of any patients surviving organ failure (grade 4 complication) can be explained by the limited intensive care facilities. Changes in postoperative management could contribute to a reduction in mortality.

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**0940: DOES THE IMPLEMENTATION OF A PREOPERATIVE BOOKING CARD INCREASE COMPLIANCE WITH ADMINISTRATION OF ANTIBIOTICS IN SEPTIC PATIENTS UNDERGOING EMERGENCY LAPAROTOMY SURGERY AT EAST LANCASHIRE HOSPITAL TRUST (ELHT)?**

O. Greenham 2, D. Subar. Royal Blackburn Hospital, Lancashire, UK.

**Aim:** To identify if a preoperative booking card for septic patients undergoing emergency laparotomy promotes administration of antibiotic in accordance with hospital sepsis guidelines. These state antibiotics must be administered within three hours of diagnosis.

**Method:** A retrospective audit was undertaken over a 10-month period using a hospital database to identify septic patients who underwent emergency laparotomies and to identify if booking cards were completed. Patient clinical notes were used to identify timings of sepsis diagnosis and administration of antibiotics.

**Result:** 36 patients were identified with complete data, of which 15 (41.7%) had booking cards. All patients (100%) received antibiotics prior to completion of a booking card. Time from sepsis diagnosis to...
administration of antibiotics was 91.7% in A&E and 53.9% in surgical triage unit, in accordance with hospital sepsis guidelines.

**Conclusion**: Emergency laparotomy booking cards do not appear to affect the administration of antibiotics. However, the results demonstrate a low completion rate of preoperative booking cards. Furthermore, there is poor compliance with hospital sepsis guidelines within some hospital departments. A change in clinical practice is needed to improve compliance with these guidelines.

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**0983**: RED CELL DISTRIBUTION WIDTH AS A PREDICTOR OF 30 MORTALITY, A SINGLE CENTRE REVIEW

E. Gaines, J. Gowar, L. Parkinson, T. Evans. **Royal Glamorgan Hospital, Wales, UK.**

**Background**: Red cell distribution width (RDW) is a measure of the variation in red blood cell volume. Elevated red blood cell distribution width (RDW) has been noted to have a prognostic value in healthy adults of 45 years of age. The study assesses the RDW’s ability to predict 30 day mortality in patients undergoing emergency laparotomy.

**Method**: A retrospective search was performed of a single centre database to look at all emergency laparotomies for the year 2014. The RDW for each patient had been measured pre operatively and this compared to outcomes at 30 days.

**Result**: In 2014 87 procedures met the NELA criteria for emergency laparotomies. There were 23 deaths at 30 days. The mean ages of those alive at 30 days was 60 (21-86), while the mean age of those dead at 30 days was 67 (49-89). There was a difference in scores and RDW between the alive and dead groups 14.1 and 15.9 respectively, multivariate analysis shows RDW is the only statistical difference at p<0.05 level.

**Conclusion**: RDW appears to have a predictive value in emergency laparotomy outcomes. Further work is needed to investigate this phenomenon.

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**1065**: DRIVING AFTER SURGERY. A LEGAL STANDPOINT FOR THE PATIENT AND THE SURGEON

R. Karthiagan, A. Shaw, UJ. Wali, Guy’s and St Thomas’ NHS Foundation Trust, London, UK; St George’s Hospital, London, UK.

**Introduction**: Returning to driving is often a question asked by patients undergoing surgery. No definitive guidance exists. The RCS advise speaking to insurance companies regarding time frames.

**Objective**: To investigate current recommendation to when a patient can go safely back to driving following surgery.

**Method**: A telephone survey was conducted of UK car insurers to discuss their recommendation regarding their policy with regards to driving post operatively.

The DVLA, BMA, MDU websites were reviewed, each institute were contacted regarding their advice for driving after surgery and the legal standpoint.

**Result**: None of the insurance companies had any stipulations in place regarding driving after surgery, they stated that the patient should ask their operating surgeon. However if a patient were to crash in this time frame then the policy would be invalid. The DVLA had no information on their website. The BMA provided no legal advice and referred the issue to the MDU who again stated that this was for the operating surgeon to decide.

**Discussion**: No rules are currently present. It appears to be the clinician’s decision as to when a patient can return to driving. We would recommend that patients following surgery are able to make an emergency stop.

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**1113**: DOES WRITTEN INFORMATION INFLUENCE POST-OPERATIVE UNDERSTANDING?

K. Burns, H. Wilton. **The Lister Hospital, Stevenage, UK.**

**Objective**: A study of general surgical patient understanding related to provision of written information.

**Method**: Over a two week period we surveyed surgical inpatients on day 1 or 2 post-operative. Patients’ recall of the information discussed at the time of consent was compared with information on Consent Form 1. In a second cycle, new patients undergoing emergency appendicectomy were given written information pre-operatively and their post-operative recall assessed.

**Result**: 40 patients were surveyed. Provision of written information was better amongst elective patients (88%) compared with emergency patients (15%). Patients that had received written information showed greater recall of procedure risks.

**Conclusion**: Patient understanding about surgery may be improved by provision of written information. Within our trust there is a need for greater provision of written information, in particular amongst emergency general surgery patients.

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**1130**: POST-OPERATIVE OUTCOMES FOLLOWING EMERGENCY LAPAROTOMY AMONGST PATIENTS WITH A PREDICTED MORTALITY >10%

J. Mason, K. Hurst, V. Vidart, R. Ravindran, C. Lewis. **Surgical Emergency Unit, Oxford, UK.**

**Introduction**: RCSEng recommend that patients with >10% risk of mortality (using P-POSSUM) are admitted to HDU/ITU post-operatively. This raises challenges in hospitals that lack separate HDU facilities. This audit aims to investigate morbidity and mortality amongst patients undergoing emergency laparotomy with a pre-operative risk of mortality >10%.

**Method**: A retrospective audit of all NELA-eligible laparotomies performed in an emergency surgical unit over a 1-year period.

**Result**: 148 laparotomies were reviewed (60, 40.5% female, median age 68, range: 18-93). The most common indication for surgery was bowel obstruction (59, 40.5%). The median risk of mortality was 6.8% (range: 0.6-99.5%), of whom 57 (38.5%) patients had a risk of ≥10%. Of these 57 patients, 33 were transferred to ITU post-operatively where the median length of ITU stay was 3 days (range: 1-39), 23/24 high-risk patients (risk of mortality: 10.0-66.3%) that were transferred to the ward post-operatively survived to discharge with a median total length of stay of 18 days (range: 4-149). There were 13 mortalities (8.8%), 12 of which occurred within the high-risk group (risk of mortality range: 15.5%-95.5%).

**Conclusion**: Patients undergoing emergency laparotomy with a pre-operative mortality of >10% can be managed safely on the ward if staff are appropriately trained.

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**1140**: ARE IMAGING MODALITIES HELPFUL TO PREDICT THE NEED FOR DIAGNOSTIC LAPAROSCOPY IN ACUTE APPENDICITIS?

Z. Rokan, A. Shaw, B. Das, S. Marsden, A. Wan. **St. George’s Hospital, London, UK.**

**Aim**: To assess whether imaging assists with decision making for diagnostic laparoscopy (DL) in suspected acute appendicitis.

**Method**: We reviewed all patients over 16 years old who underwent laparoscopic or laparoscopic-converted appendicectomies, with or without imaging, from June-December 2015. Patients were identified with data collected using electronic theatre programmes and Electronic Patient