cancers (35 patients) four showed an upgraded Gleason grade in the transitional zone than the peripheral zone. Twenty biopsies confirmed the same Gleason grading in both zones, and eleven biopsies showed a downgrading in the transitional zone.

Conclusion: Routine transitional zone biopsies do not significantly increase the detection rate of prostate cancer. However, they do provide information regarding the grading of the cancer which can further impact on management.

1020: ASSESSMENT OF SYMPTOMATIC OUTCOMES OF SACRAL NEUROMODULATION FOR THE TREATMENT OF DETRUSOR OVERACTIVITY
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Aims: To assess symptoms in patients who have undergone implantation of the Interstim™ neurostimulator using the ePAQR online questionnaire.

Methods: ePAQR™ is an interactive online instrument developed in Sheffield. It assesses symptoms relating to the pelvic floor and the impacts on quality of life. Five patients with detrusor overactivity with urinary incontinence refractory to medical management completed the online questionnaire pre and post implantation. Urinary symptoms are calculated. A score of 0 indicates no symptoms, whilst a score of 100 indicates maximum possible symptoms. Urinary symptoms are categorized into: pain, voiding, overactive bladder and stress incontinence. Quality of life is also assessed.

Results: All patients completed an ePAQR™ score pre treatment and proceeded to percutaneous nerve evaluation (PNE) followed by permanent implantation. One patient had no improvement in symptoms during PNE and elected for intravesical botox treatment. Mean pre implant scores: 48.15 (11-100); Mean PNE scores: 14.05 (0-67); Mean post implant scores: 8.85 (0-33).

Conclusion: A significant improvement in symptoms and quality of life in patients receiving permanent neuromodulation implants was seen. The use of ePAQR™ provides an efficient and quantitative means to record symptoms. Further patient numbers are required to assess sacral neuromodulation and ePAQR™ as an assessment tool.

1094: SURGICAL MANAGEMENT OF LOCALISED RENAL CANCER; THE CASE FOR LAPAROSCOPIC PARTIAL NEPHRECTOMY
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Introduction: Although historically radical nephrectomy has been the mainstay of management for localised renal cell carcinoma (RCC), partial nephrectomy (PN), is now recommended for T1 (<7cm) lesions.

Aim: To determine current practice with respect to management of T1 RCC in a tertiary referral unit.


Results: Of 57 patients undergoing surgery, 47 (82.4%) underwent laparoscopic radical nephrectomy (LRN) and 9 patients (15.8%) were treated with PN. One patient underwent open radical nephrectomy (ORN). At the time of multidisciplinary registration, partial nephrectomy was only considered in 10 patients (17.5%).

Median length of stay was shorter in LRN (4 vs. 7 days), with fewer complications. Mean increase in creatinine from baseline was 41.0 in patients undergoing LRN/ORN, vs. 12.5 in those undergoing PN (t = 3.4662, p = 0.0011). In the LRN/ORN group, a new decline in eGFR to < 45 was noted in 29% of patients, vs. 11% in the PN group.

Conclusion: Mainstay of management for T1 RCC is currently LRN. Whilst a laparoscopic approach provides a LOS advantage and reduces complication rates, the loss of an entire renal unit may give rise to CKD related morbidity.

1100: HOW TO IMPROVE THE LEARNING CURVE OF COMPLEX PROCEDURES OR NOVEL TECHNIQUES IN LAPAROSCOPY: THE CONCEPT OF WHOLE PROCEDURE EQUIVALENT
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Aim: In a linear model of apprenticeship, easy procedures are allocated to training. By the end of the curriculum little time is left to learn complex procedures for which demand for training is high. These are partly addressed by sequential-modal training. We propose a novel concept of non-sequential modular model “whole procedure equivalent” (WPE).

Methods: Laparoscopic-prostatectomy is broken down into steps that can be learnt independently without pre-set orders. Trainees record performance on a developed e-portfolio for each step on every case following feedback. There is a colour code of performance; deep blue when the trainee was in a trainer role, green when a step was completed without supervision and amber when performed under supervision.

Results: Six surgeons have trained to proficient level: four were sixth-year fellows and two were senior surgeons in personal development. Each surgeon by the end of the training has performed independently with a smaller number of operations with competency gained through a far larger number of WPE, growing rapidly after 24 cases.

Conclusion: By exploring ways of facilitating training in challenging surgical procedures a model of learning complex laparoscopic skills has been designed. The non-sequential model allows for a higher ratio performance/attendance than existing models.

1109: ANTERIOR MINI PYELOPLASTY FOR ADULT PUJ OBSTRUCTION: A BETTER ALTERNATIVE THAN LAPAROSCOPIC PYELOPLASTY IN SELECTED CASES?
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Aim: Open pyeloplasty is the gold standard treatment for pelviureteric junction (PUJ) obstruction. Laparoscopic pyeloplasty is increasingly becoming a popular alternative but has inherent difficulties with laparoscopic suturing and this can often affect the final outcome. We describe a technique of anterior mini pyeloplasty which carries the advantage of minimally invasive surgery and is as effective as the standard open pyeloplasty

Method: 12 patients underwent open mini pyeloplasty at our centre for PUJ obstruction. The surgical technique involved approaching the PUJ through an anterior muscle splitting 3-4 cm transverse incision.

Results: Mean patient age = 56, average BMI=23; mean operation time=129 minutes; mean decrease in post op Hb = 1.4 mg/dl; median hospital stay : 3.6 days. None of the patients required parenteral analgesia after day 2. All symptomatic patients were symptom free postoperatively. All patients showed an improvement in drainage on postoperative MAG3 renogram.

Conclusions: Anterior mini pyeloplasty is quite popular in children but this is the first presented series in an adult population. It has all the advantages of minimally invasive surgery and has comparable efficacy to that of standard open pyeloplasty. We conclude that anterior mini pyeloplasty is safe and successful in selected cases.

1150: OPTIMAL MANAGEMENT OF DETRUSOR UNDERACTIVITY IN MEN WITH SYMPTOMS SUGGESTIVE OF BENIGN PROSTATIC OBSTRUCTION
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Aims: To evaluate whether urodynamic assessment of patients with chronic urinary retention following a period of clean intermittent self-catheterization (CISC) would allow better management of patients with detrusor underactivity (DU).

Methods: Forty eight patients were recruited. Retention was initially relieved with indwelling catheterization. Patients were subsequently taught CISC and reviewed at three months. Patients with resuming motor function were appropriate for urodynamics. Those with confirmed DU continued CISC and those with benign prostatic obstruction (BPO) were offered transurethral resection of the prostate (TURP).

Results: Mean age was 79 years (30-91). At three month review, 42 (88%) patients were appropriate for urodynamics. Twenty six patients (62%) were found to have BPO of which 22 had a TURP. Following surgery, 21 (95%) were voiding well.

Sixteen patients (38%) were found to have DU and subsequently continued treatment with CISC and reviewed in clinic for change in bladder function.

Conclusion: CISC is the gold standard treatment for DU. A key cause of poor DU in TURP results is underlying DU. The use of initial CISC allowing bladder rest followed by urodynamics on selected patients helps identify
VASCULAR/ENDOVASCULAR SURGERY

0042: VALIDATION OF A REGRESSION MODEL TO ACCURATELY DETERMINE THE EFFECTS OF IPSILATERAL CRITICAL CAROTID STENOSIS ON CONTRALATERAL DUALPLEX CAROTID VELOCITIES

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Introduction: The aim of this study is to assess the cost effectiveness of the 120W HPS photoselective vaporization of the prostate (PVP) in comparison with transurethral resection of the prostate (TURP).

Methods: 60 PVP procedures performed over a 3 year period (Feb 2009 – July 2011) were compared with 60 TURP procedures performed during the same time period. The focus of the paper was primarily on the potential cost saving with the PVP procedure due to a shorter inpatient hospital stay.

Results: Of the 120 procedures performed, 60 were PVPs while 60 were TURPs. 15 (25%) PVPs were performed as a day-case procedure, while 45 (75%) were performed as an in-patient procedure. The median length of stay for a PVP in our institution is 4 days (range 0 – 29 days). The median length of stay for TURP is 7 days (range 3 – 26 days). In our institution, the mean cost of a TURP is €11,200, the mean cost of a PVP is €7,300 while the day case PVP costs €2,800.

Conclusions: This study highlights the potential savings to public hospitals with a shorter in-patient hospital stay for patients undergoing the PVP procedure.

Method: Patients commencing haemodialysis through Radiocephalic or Brachiocephalic fistulae were identified. Comparison was made to a control group who used the laddering method prior to the introduction of BH. Data was collected prospectively. Groups were compared by chi squared, unpaired t-test and log-rank methods.

Results: There were no statistical differences (p=0.05) between BH (n=88) and controls (n=322) with regard to demographics. At 2 years, AVF cannulated by BH had a higher patency rate at all time points (6 months 90.9% vs. 81.1%, 12 months 80.4% vs. 74.5%, 2 years 73.3% vs 67.1%) but this did not reach statistical significance (p=0.227).

Conclusion: We have shown clinical non-inferiority of the BH technique on AVF secondary patency compared to a standard cannulation technique. Previous studies revealed patient and nursing preference for BH over the laddering technique and therefore we suggest this should become the first line method of AVF cannulation.

0163: FACTORS AFFECTING LENGTH OF STAY (LOS) IN ELECTIVE AAA SURGERY

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Objective: Vascunet Registry data shows that UK elective Abdominal Aortic Aneurysm (AAA) repair patients have the worst length of stay (LOS) data in Europe. This study examines risk factors associated with an increased LOS in AAA surgery.

Methods: We examined 75 consecutive elective AAA repairs performed between 1st September 2009 – 31st October 2010. Pre-operative, intra-operative and post-operative factors were analysed using multinomial regression analysis.

Results: The median LOS was 7 days (2-33) for OS vs. 2 days (1-47) for EVAR. 30-day mortality was 2% for EVAR and there were no deaths for open surgery. 31% of EVAR patients stayed > 3 days and 63% of open surgery patients stayed > 7 days. Factors associated with increased LOS were age over 75 (Chi= 29.45, p<0.031) and any post-operative complication (Chi= 35.32, p=0.006) with respiratory infection being the most common complication (7/19 patients). The average LOS more than doubles if any post-operative complication is present (5.6 days versus 11.85 days).

Conclusions: Our study suggests that there may be potential for reducing LOS in elective AAA surgery for patients > 75 yrs and those who may be at risk of post-operative respiratory infection by introducing targeted measures in the Vascular Society AAAQIP.

0168: THE FRESH FROZEN PULSATILE HUMAN CADAVER MODEL. A NOVEL TECHNIQUE FOR TRAINING ENDOVASCULAR PRACTITIONERS. A TRIAL OF FACE VALIDITY

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Aims: Determine the face validity of a pulsatile human cadaver model (PHCM) for training endovascular practitioners.

Methods: 11 endovascular clinicians performed two procedures (catheirisation of the left renal artery and left subclavian artery) on PHCM, and Simbionix angiomenter virtual reality simulator (SVR). After training participants rated statements relating to their experience on a numerical scale from 1 to 5, with 1 representing the strongest agreement with the statement.

Results: Compared to live patients, candidates scored statements on PHCM favourably regarding “realism of vascular access” (mean 2.27, [SD +/-0.75]), “guide-wire manipulation” (1.36, [+/-0.48]), “vessel catheterisation” (1.64 [+/-0.64]), and “performing an angiogram” (2.7 [+/-1.02]). Compared to SVR, candidates scored PHCM favourably, regarding “realism of vascular access” (1.73 [+/-0.75]), “guide-wire manipulation” (2.18 [+/-0.58]), “vessel catheterisation” (1.82 [+/-0.71]), and “performing an angiogram” (2.7 [+/-121]). Candidates “preferred training on PHCM” (1.91 [+/-0.67), would “recommend PHCM to others” (1.55 [+/-0.5]) and no candidates “objected to training on human cadavers” (1.64 [+/-0.88).

Conclusions: This is the first trial in world literature to assess the validity of a PHCM for training endovascular practitioners. It scored favourably compared to both live patients and SVR. The PHCM holds exciting training potential.