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resection for metastatic GIST, with relation to the recently proposed pre-treatment classification by Cananzi et al.
Methods: A retrospective case note analysis was performed. Pre-treatment disease extent was classified as per Cananzi et al: type I-II non-metastatic, resectable disease; III metastatic (synchronous) resectable disease; IV unresectable disease. The primary outcome was 5-year survival; secondary outcomes were disease free intervals and treatment practices.
Results: Twelve patients underwent liver resection for metastatic GISTs. Pre-treatment, patients were classified as: type I in 3; type II in 5; type III in 2; type IV in 2. Five-year survival was 100%, 60%, 50% and 100% respectively. Type I to III patients were treated with surgical resection only. Type IV disease was downstaged with neo-adjuvant TKIs prior to resection. The disease free interval was 73, 28, 28 and 53 months respectively (mean 36 months).
Conclusions: Neo-adjuvant TKIs therapy for metastatic GIST has a potentially significant role in improving 5-year survival and disease free intervals.

0445: A CLOSED LOOP AUDIT DEMONSTRATES GREAT IMPROVEMENT IN ACUTE PANCREATITIS CARE

Peter Davies*, Hareth Bader, Chris Battersby, Debashish Maitra. *St Helens and Knowsley NHS Trust, Merseyside, UK.*

Introduction: The British Society of Gastroenterologists (BSG) updated guidelines on the management of acute pancreatitis in 2005. This audit aimed to improve acute pancreatitis care in accordance with those guidelines.
Methods: An initial audit of all 39 patients with acute pancreatitis in October-December 2011 was undertaken. Improvements were made through arranging group teaching for junior doctors, extra cholecystectomy lists, a 7-days per week ultrasound service (5-days previously) and combined microbiology and surgical ward rounds. Liaison with gastroenterologists improved ERCP availability. A retrospective re-audit was undertaken of all 50 patients in February-March 2013 to complete the audit cycle.
Results: Modified Glasgow Score was completed in 98% of re-audit cases (85% previously). Antibiotic prescription was considered appropriate in 90% (47%). Gallstone pancreatitis was managed by cholecystectomy, either as an inpatient or within two weeks, in 77% (10%). Ultrasound was performed within 24 hours of admission in 66% (28%), ERCP was delayed in 2% (5%) and overall mortality was 8% (10%).
Conclusions: Acute pancreatitis care was improved following several changes. Current care follows recommended guidelines but there is room for improvement, notably in improving ultrasound access and managing gallstone pancreatitis.

0502: POST OPERATIVE SURGICAL DRAINS AFTER PANCREATICODUODENECTOMY: SINGLE VERSUS DUAL DRAINAGE

Jamal Ghaddar*, William Paxton, Chris Briggs, Somaiah Aroori. *Derriford Hospital, Plymouth, UK.*

Introduction: The placement of one or more abdominal drains after pancreaticoduodenectomy is common practice with the rationale that this facilitates early diagnosis of complications.
Increasing evidence suggests that drainage after abdominal surgeries may be unnecessary.
Our aim was to evaluate the outcomes following the use of one drain versus two drains following pancreaticoduodenectomy.
Methods: We retrospectively reviewed 182 patients chosen at random out of a pool of 260 patients who had a pancreaticoduodenectomy between 2006 and 2013.
Patients were subdivided into two groups; those with one drain (group 1) and patients with two drains (group 2). Data was then analysed according to demographic factors such as age/gender and peri-operative factors such as type of pancreatic anastomosis, date of drain removal, complications, means used to diagnose and treat complications, length of stay, clinical details, cancer origin and histology reports.
Results: There were 37 patients in group1 and 145 patients in group2. The length of hospital stay was significantly shorter in group 1 (13.16 vs 15.39 days, P<0.05). There was no statistical difference in the rate of overall complications, intervention or re-admission in both groups.
Conclusions: The use of one drain after pancreaticoduodencetomy may facilitate earlier discharge without increasing morbidity, mortality, re-admission and intervention rate.

0728: ROUTINE COAGULATION SCREENING IS UNNECESSARY PRIOR TO ERCP IN NON-JAUNDICED PATIENTS; A MULTI-CENTRE STUDY

Sarah Walker*[2], Katie Mellor[2], Jonny Nicholls[1], Richard Egan[1], Michael Stechman[1]. [1]*University Hospital of Wales, Cardiff, UK;* [2]*Princess of Wales Hospital, Bridgend, UK.*

Introduction: Guidelines suggest performing coagulation screening prior to endoscopic retrograde cholangiopancreatography (ERCP). We hypothesise that coagulation is rarely deranged in the absence of biochemical jaundice.
Methods: All ERCP procedures performed at two centres during a 16 month period were assessed. For each patient demographic data, pre-procedure bilirubin and prothrombin time (PT), diagnosis and bleeding complications were recorded. Exclusion criteria were; incomplete records, anti-coagulation therapy or inherited coagulopathy.
Results: The cohort was divided into jaundiced (n=419) and non-jaundiced (n=374) groups for analysis. Seven per cent (n=28) of jaundiced patients had a significantly prolonged PT (>16.8 seconds = INR of ≥1.5). One non-jaundiced patient had significantly prolonged PT, whilst 5.9 per cent (n=22) had a mildly raised PT (above normal range); none of these had bleeding complications. A significant difference in PT between groups was seen (mean ±SD 13.0 ±6.3 vs. 11.0 ±1.2 seconds; p<0.001 t-test). The diagnosis, ERCP procedures, and bleeding complications were equivalent between groups and centres. The approximate cost of coagulation tests in the non-jaundiced cohort was £7,500.
Conclusions: Patients with normal bilirubin levels rarely have deranged coagulation suggestive of acquired coagulopathy. A negative bleeding history and normal liver function tests makes coagulation screening an unnecessary and expensive investigation.

0801: FITNESS TO DRIVE ADVICE AFTER ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY (ELC) – WHOSE RESPONSIBILITY IS IT? A SURVEY OF CAR INSURANCE COMPANIES

Michael Courtney*, Bussa Gopinath, Duncan Light, Milind Rao. *University Hospital of North Tees, Stockton-on-Tees, UK.*

Introduction: Easily accessible online advice regarding return to driving following ELC is inconsistent. Driving too soon is unsafe and risks invalidating a patient's car insurance; hence patients are often advised to check their own insurance company's policy. This study aimed to review UK insurance companies' advice regarding return to driving following ELC.
Methods: An online search identified 126 car insurers; each was emailed asking when the policyholder can return to driving following ELC, and advice as to how he/she would know they were fit to drive.
Results: 26 companies were not contactable online so excluded. Of the remaining 100 companies, 62 responded: 61% stated their regulations, 39% would not communicate without a confirmed policy. All companies offering information stated that a doctor must determine the policyholder's fitness to drive, or timescale in which they cannot. 1 stated that the policyholder needed to be able to perform an emergency stop, the rest did not comment.
Conclusions: Insurance companies place the responsibility of determining fitness to return to driving with the patient's doctors. It is the doctor's duty to ensure that patients have access to this information, and that information is documented. If publically available information is to be utilised, there is a need for standardisation.

0843: HEPATIC TRANSARTERIAL CHEMOEMBOLISATION IN EAST LANCASHIRE: ACHIEVING INTERNATIONAL STANDARDS

Kenan Kursumovic*, Sam Byott, Ambareen Kausar, David Chang, Neil Wilde, Duncan Gavan. *Royal Blackburn Hospital, Blackburn, UK.*

Introduction: Hepatic Transarterial Chemoembolisation (TACE) for non-resectable Hepatocellular carcinoma (HCC) therapy exploits the preferential blood supply from the hepatic artery for delivery of antitumour therapy. It is also used for other primary or metastatic liver malignancies. We enacted a comprehensive review of the TACE service at a district general hospital in East Lancashire, United Kingdom with a focus on patient selection, complications and survival rates.
Methods: A retrospective review was performed from 2007 to 2012, against clinical practice guidelines published by CIRSE (2012) and SIR (2012).

Results: 79 procedures (42 patients) were performed, including 56 treatments (28 patients) for HCC, 19 symptomatic therapies (11 patients) for metastatic carcinoid tumours and 4 procedures (3 patients) for other liver metastases. Correct patient selection was achieved in 98% of cases (SIR/CIRSE threshold: >95%), with a 92 % technical success rate (threshold: 98%) and a 19% overall complication rate (threshold: 15%). >55% of HCC patients were alive at 20 months follow up (threshold: >50%). Symptomatic relief was achieved in most carcinoid tumour patients.
Conclusions: Our TACE service is generally performing to expected levels with survival rates in line with international practice guidelines. We envisage improvements in the technical success and complication rates as numbers increase.

0913: USE OF HIDA SCANS AND LAPAROSCOPIC CHOLECYSTECTOMY FOR ACALCULOUS BILIARY SYMPTOMS – A 4 YEAR EXPERIENCE IN A DISTRICT GENERAL HOSPITAL

A. Jones, G. Fabrizi*, I. Finlay, T. Sulkin. *Royal Cornwall Hospital, Truro, UK.*

Introduction: Recurrent reproducible RUQ pain in the absence of gallstones (acalculous biliary colic) is commonly investigated with a radioactive labelled HIDA scan to look for biliary dyskinesia. Our aim was to report on 4 years experience of HIDA scans in the investigation of acalculous biliary colic and report on ejection fractions, histological changes in any resected gallbladders, and the efficacy of laparoscopic cholecystectomy as a treatment for these patients.
Methods: Hospital records were interrogated for all patients over the last 4 years who underwent a HIDA scan for investigation of recurrent biliary symptoms who had no gallstones demonstrable on USS. HIDA scan results were then combined with histology reports and telephone follow-up to determine presence of chronic cholecystitis and degree of any symptomatic improvement following cholecystectomy.
Results: 26 patients were investigated with a HIDA scan; 24 had acalculous biliary colic. A total of 13 patients underwent cholecystectomy. 12/13 (92%) had EF<35% and 12/13 (92%) had chronic cholecystitis on histology. 7/7 patients available for long term telephone follow up reported significant or complete improvement in symptoms.
Conclusions: Despite the absence of gallstones on USS, patients with recurrent symptoms frequently have histological changes consistent with cholecystitis, and cholecystectomy is an appropriate treatment for these patients.

1024: ANALYSIS OF ENDOSCOPIC AND SURGICAL MANAGEMENT OF COMMON BILE DUCT STONES IN THE LAPAROSCOPIC ERA

Shi Ying Hey*, Peter J. Driscoll, Satheesh Yalamarthi, Andrew J. Robson. *Department of Surgery, Victoria Hospital, Kirkcaldy, UK.*

Introduction: Endoscopic retrograde cholangiopancreatography (ERCP) remains the first line intervention for common bile duct stones (CBDS). Recent popularisation of laparoscopic surgery has extended the treatment options available for CBDS management, re-opening the debate on the primary role of ERCP in CBD clearance.
Methods: ERCP records were investigated between January 2006 and April 2011. The outcome of patients who had failed CBDS removal on index ERCP was reviewed. Complications related to either endoscopic or surgical procedures were recorded.
Results: 543 patients had CBDS directly visualised. Overall endoscopic clearance rate was 90.1% (489/543). Of these, 396 (72.9%) patients had ductal clearance on the first ERCP. Of the 147 patients who had a failed index ERCP, 93/147 was eventually cleared with subsequent attempts. 11.0% of those that underwent further ERCPs following the unsuccessful index procedure developed post-ERCP complications. Of the 147, 30 (20.4%) were referred for surgical clearance, 27/30 underwent CBD exploration. Of these, 92.6% (25/27) had successful surgical CBD clearance.
Conclusions: The variable efficacy of therapeutic ERCP in CBDS clearance remains the main routine drawback and repeating the procedure may not necessarily optimise the treatment outcome. Surgical exploration should be considered after the failed index ERCP for CBDS, particularly in the context of planned laparoscopic cholecystectomy.

1075: THE TIMING OF ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY AND INPATIENT HOSPITAL STAY AUDIT

Karim Amer*, Diwakar Sarma, Saurav Chakravartty, Avril Chang. *King's College Hospital, London, UK.*

Introduction: The timing of Endoscopic Retrograde Cholangiopancreatography (ERCP) for acute biliary obstruction is not defined by any national UK guidelines. Recent literature states better patient outcomes when ERCP is performed within 24-48hrs of admission for gallstone pathology and within 24hrs for severe acute cholangitis. We aim to audit clinical practice at King's College Hospital London and establishing trust timing guidelines for ERCP referral.
Methods: Electronic data was collected prospectively and analysed retrospectively. Audit inclusion criteria identified inpatient's receiving ERCP for biliary obstruction between January 2010-2011. Inpatient stay was compared with timing to ERCP (requested and received <72hrs or >72hrs upon admission), accounting for reduced weekend services. ERCP fast-tracking guidelines were presented to both surgical and endoscopy teams. Re-audit assessing data between April 2011-2012 was completed to identify service improvement.
Results: A 6% increase was noted in ERCP completed <72hrs. Median total inpatient stay was 9 days if time to ERCP was <72hrs and 15 days if >72hrs. The estimated additional cost per-patient if ERCP requested >72hrs is between £2400-£3900.
Conclusions: Time to ERCP <72hrs of admission significantly reduces inpatient hospital stay thus, consequently improving service delivery and patient care. A financial incentive to reduce time to ERCP is clearly highlighted.

1344: RISK OF COMMON BILE DUCT STONES WHEN DERANGED LFTS HAVE RETURNED TO NORMAL

Ayoola Awopetu, Jeremy Williamson, Waseem Hameed, Parinaz Sagni*, Richard Morgan. *Ysbyty Glan Clwyd, North Wales, UK.*

Introduction: To investigate the incidence of common bile duct (CBD) stones in patients who have deranged LFTs which return to normal prior to cholecystectomy.
Methods: A retrospective review of patients who underwent laparoscopic cholecystectomy and cholangiography for symptomatic gallstone disease in a 9 year period, in whom the LFTs had been deranged at presentation, but had returned to normal prior to surgery.
Results: Some 239 patients underwent laparoscopic cholecystectomy with operative cholangiogram. All had deranged LFTs at presentation, but normal LFTs at the time of surgery. 28 had CBD stones (11.7%). Pre-operative CBD dilatation was found in 63 patients; of these, 12 (19%) had CBD stones.
Conclusions: CBD stones are an unusual finding in this group of patients who present with biochemical evidence of a CBD stone, but who appear to pass the stone. In these patients, CBD stones are more common in patients with biliary dilatation on pre-operative imaging. Even with a non-dilated biliary tree, CBD stones are found in a small but clinically significant number of patients. Routine operative cholangiography is therefore recommended to prevent post-operative problems caused by retained CBD stones.

Maxillofacial surgery

0138: PATIENT KNOWLEDGE ON ORTHOGNATHIC SURGERY

Tara Lee*, John Rowson. *Queen's Medical Centre, Nottingham, UK.*

Introduction: To find out how well informed orthognathic patients felt they were prior to surgery. To gain insight into the overall patient experience. To seek feedback on how to improve our service. Design: Retrospective audit carried out at Queen's Medical Centre, Nottingham.
Methods: 66 Questionnaires sent to patients who underwent surgery between 1/1/2010 and 31/12/2012. 9 Questions were related to patient knowledge. 4 questions were related to the current orthognathic information leaflet, how patients preferred information, their use of websites and their hospital experience. Gold Standard: 90% of patients should report feeling well informed for each question relating to patient knowledge.
Results: 39 Questionnaires returned. Of the 9 questions related to patient knowledge- 5 questions surpassed the 90% standard and 4 questions fell below. The 4 areas where patients felt they needed more information were on recovery time, possibility of wiring jaw together, postoperative dietary requirements and possibility of relapse.
Conclusions: Most patients felt well informed and had a positive experience. A revised orthognathic information leaflet will be written placing emphasis on the 4 areas where patients felt less informed. Re-audit is planned in 2 years to assess the impact of the leaflet.