



# The Association of Surgeons in Training

**Aims:** ERCP is usually performed in OGSD patients. Most patients are subsequently counselled for cholecystectomy. This may be associated with significant morbidity in elderly patients. This study aims to assess if cholecystectomy can be safely deferred in elderly patients following successful ERCP for OGSD.

**Methods:** All patients >75 year-old with OGSD, who underwent ERCP (June 2004–2008) in 2 centres, were included. Information regarding stenting, complications (failure, bleeding, cholangitis and stent migration), 30-day mortality and symptoms recurrence was retrospectively collected. The median follow-up period was 9 (6–36) months. Difference in ERCP outcome between the 2 centres was assessed by two-tailed t-test.

**Results:** Centre 1 (n = 54) Centre 2 (n = 51) Total (n = 105) Sphincterotomy only 33(61.1%) 29(56.9%) 62(59%) Stent insertion 21(38.9%) 22(43.1%) 43 (41%) Complications 3(5.6%) 7(13.7%) 10(9.5%) 30-day mortality 3(5.6%) 1 (2%) 4(3.8%) Symptoms recurrence 11(20.4%) 5(9.8%) 16(15.2%) Cholecystectomy 4(7.4%) 11(21.6%) 15(14.3%) Overall, 85.7% of patients did not require cholecystectomy during the follow-up period. There was no difference between centres regarding number of stents inserted and 30-day mortality ( $p > 0.05$ ). Centre 2 had a higher cholecystectomy and ERCP complication rate ( $p < 0.05\%$ ).

**Conclusions:** The preliminary data suggests that cholecystectomy is not required in the majority of elderly patients with OGSD following successful ERCP. Longer follow-up is needed to determine if ERCP offers definitive treatment.

## ROLE OF ULTRASOUND GUIDED TRANSVERSUS ABDOMINIS PLANE (USTAP) BLOCK IN ANALGESIC SUPPLEMENTATION FOR LAPAROSCOPIC RADICAL PROSTATECTOMY. PRELIMINARY FINDINGS

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**Introduction:** Ultrasound Guided Transversus Abdominis Plane (USTAP) Block is a new regional anaesthetic technique that aims to block the abdominal neural afferents by instillation of local anaesthetic into the neurofascial plane that lies between the transversus abdominis and internal oblique musculature. We conducted a preliminary evaluation of the analgesic efficacy of this approach for Laparoscopic Radical Prostatectomy (LRP).

**Methods:** Forty men undergoing LRP were given different modes of analgesia. Group 1 had general anaesthetic (GA) alone, Group 2 had GA and epidural, Group 3 had GA and patient controlled analgesia and Group 4 had bilateral USTAP Block. Post-operatively all groups received acetaminophen and non-steroidal anti-inflammatories as required. Each patient was objectively assessed at 24 hours.

**Results:** The percentages of patients requiring morphine in the first 24 hours / the mean visual analogue pain scores at 24 hours were: Group 1 – 47/3.5; Group 2 – 100/3.0; Group 3 – 100/2.0; Group 4 – 47/1.2.

**Conclusions:** USTAP Block offers satisfactory analgesic effects for patients undergoing LRP and appears to be safe with no complications. The role of USTAP in LRP and other minimally invasive urological procedures should be explored further.

## THE ROLE OF BONE SCAN AND PSA IN PATIENTS WITH NEWLY DIAGNOSED PROSTATE CANCER

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**Objective:** To determine if bone scanning is necessary in newly diagnosed cases of prostate cancer with PSA < 20ng/ml.

**Material and methods:** We analyzed the data of all our 246 patients with newly diagnosed prostate cancer from January 2007 to January 2009. We excluded 18 of these patients without histology or bone scan leaving 228 patients.

**Results:** 44 patients had a positive bone scan, of which 37 were confirmed with further radiological imaging. Out of these 37 patients; there were 11 (8%) with PSA < 20; and 4(5%) with PSA < 10 (PSA values: 1.89, 7.37, 7.6 and 8.73). There were 5 patients with PSA < 20 who had moderately differentiated cancer and of these 4 had PSA < 10.

**Conclusion:** Bone scanning may be necessary in newly diagnosed cases of prostate cancer with PSA < 20ng/ml. Our study indicates that a larger proportion of patients in this category may have a positive bone scan than earlier studies have shown. It is important not to over-treat these patients with radical treatment, as would occur without the information provided by bone scans. Limiting the number of bone scans in a cost saving effort may therefore compromise patient care.

## SUCCESSFUL OUTCOME AFTER LAPAROSCOPIC FUNDOPLICATION IN PATIENTS WITH DOCUMENTED GASTRO-OESOPHAGEAL REFLUX FOLLOWING LUNG TRANSPLANTATION

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**Aims:** To evaluate the prevalence of severe gastro-oesophageal reflux (GORD) following lung transplantation and outcome after laparoscopic fundoplication.

**Methods:** A retrospective analysis was performed on all patients who developed severe GORD requiring laparoscopic fundoplication following single or bilateral lung transplantation at a single institution from 2002–2009. GORD was confirmed by oesophageal manometry and 24 hour pH/bile monitoring. Pre and post-operative pulmonary function tests were analysed.

**Results:** 10 of 76 lung transplant patients (13.2%) underwent laparoscopic fundoplication. All patients were already on a H2 antagonist or proton-pump inhibitor. Of these 10 patients, pH studies demonstrated severe acid/bile reflux with delayed clearance. 1 patient could not tolerate oesophageal manometry but demonstrated endoscopic signs of severe reflux oesophagitis. The mean total reflux time over 24 hours was 12.4% (normal < 4%). The mean total number of reflux episodes over 24 hours was 152. The average De Meester composite score was 48.2 (normal < 14.72). 4 patients had upper oesophageal reflux, which was considered significant. The average time from transplantation to fundoplication was 26.2 months. All procedures were completed laparoscopically and the 30 day mortality was zero. After fundoplication surgery, 8 of 10 patients demonstrated improvement in pulmonary function (80%) and resolution of reflux symptoms was achieved in 90%.

**Conclusions:** GORD occurs commonly in patients following lung transplantation. Laparoscopic fundoplication can be performed safely with reduction in the risk of microaspiration, diffuse alveolar damage and allograft failure, resolution of GORD symptoms and improvement in respiratory function.

## INTRA-OPERATIVE SELECTIVE RENAL ARTERY BALLOON OCCLUSION LAPAROSCOPIC RADICAL NEPHRECTOMY – TECHNIQUE AND OUTCOMES

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