0314: STRICT ADHERENCE TO BSG GUIDELINES REQUIRED FOR CHOLECYSTECTOMY FOLLOWING PANCREATITIS TO PREVENT HIGH READMISSION RATES

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Background: The current British Society of Gastro-enterology guidelines (2005) for the management of acute pancreatitis suggests that patients with gallstone-induced mild pancreatitis should undergo cholecystectomy with operative cholangiography, unless unfit for surgery, in order to prevent recurrence of pancreatitis. Cholecystectomy should be done at the same admission or within two weeks after discharge and delayed in patients with severe acute pancreatitis until systemic disturbance have resolved.

Methods: Data from Patients admitted with acute pancreatitis from January 2010 to December 2010 were collated.

Results: Of the 117 patients admitted with acute pancreatitis, 51 patients had gallstone-related pancreatitis. 21 patients were known to have gallstone disease from previous admissions. Of the 30 admissions with primary gallstone presentation, 20 were placed on the cholecystectomy waiting list. Eleven (55%) patients were re-admitted, and 6 patients underwent emergency cholecystectomy. The overall waiting list time was 18 (2 - 36) weeks. Of the 21 patients with previous admission for gallstone-related complications, 1 had an emergency cholecystectomy while 15 patients were placed on the waiting list. 5 patients (33.3%) re-presented with 3 patients then undergoing an emergency cholecystectomy.

Conclusion: High re-admission rates following gallstone pancreatitis are a result of non-adherence to the BSG guidelines, especially in female patients.

0212 – WINNER OF ALSGBI TRAINEE PRIZE: SINGLE INCISION COMPARED TO STANDARD LAPAROSCOPIC CHOLECYSTECTOMY

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Introduction: Single-incision laparoscopic surgery is gaining momentum in general surgery. The aim of this study was to compare outcomes for day case single-incision laparoscopic cholecystectomy (SILC) with standard laparoscopic cholecystectomy (StdLC).

Methods: Patients scheduled for day case laparoscopic cholecystectomy were block randomized to SILC or StdLC. Patients were prospectively scored for pain, wellbeing, satisfaction with wounds and recovery on a visual analogue scale (VAS) on days one and seven post-operatively.

Results: 49 patients were included in the study (SILC=24; StdLC=25). There were no differences in age, sex, ASA grade and BMI. Two patients were excluded from the study, one from the SILC group and one from the StdLC group. There was no significant difference in the VAS on day one. However, on day seven the SILC group rated their cosmesis significantly higher than the StdLC group (p = 0.03). There was no difference in pain wellbeing or strength between the groups.

Conclusion: SILC is feasible, safe and comparable with StdLC. SILC is associated with superior cosmesis.

0257: DOES SEQUENTIAL HEPATIC ARTERY EMBOLISATION INCREASE COMPLICATIONS AND MORTALITY FOLLOWING LIVER RESECTION COMPARED TO PORTAL VEIN EMBOLISATION ALONE?

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Aim: To evaluate the feasibility of portal vein embolisation (PVE) and sequential hepatic artery embolisation (HAE) to increase the future liver remnant (FLR) prior to liver resection.

Methods: All patients undergoing PVE and sequential HAE between January 2006-May 2011 were identified from a prospectively held database. These patients were discussed at MDT meetings to decide the necessity for FLR augmentation.

Results: 50 patients underwent right PVE with 33 (66%) progressing to resection. The median FLR of those who progressed to resection following PVE, by CT volumetry, was 384.5cc (330-490), significantly more than those who did not, 237cc (110-280)(p<0.03). All patients with small FLR following PVE (n=6) underwent HAE (with 5 undergoing resection). HAE increased the FLR by a further 99.8cc (80.5-130cc). Following resection after PVE and sequential HAE 9/33 (27%) and 3/5 (60%) respectively suffered serious complications (Clavien-Dindo 3/4). There were 6 post-operative deaths, 5/33 (15%) after PVE and 1/5 (20%) following sequential HAE.

Conclusion: PVE is an increasingly used technique to augment the FLR, allowing resection in a significant proportion of patients who were initially considered inoperable. Patients who do not achieve adequate hypertrophy may have HAE to increase the FLR but perhaps at the expense of increasing post-operative complications.

0323: DOUBLE BYPASS FOR INOPERABLE PANCREATIC MALIGNANCY AT LAPAROTOMY: SHOULD WE ALWAYS PROCEED?

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Aim: Double bypass, although associated with high risk of postoperative complications and mortality, is an option for those with pancreatic malignancy found to be inoperable at surgery. The aim of this study was to identify pre-operatively which patients undergoing bypass are at high risk of complications/mortality and to assess their long term outcome.

Method: Of the 576 patients undergoing pancreatic resection for malignancy from January 2006-July 2011 identified from a prospectively held database, 50 patients had a double bypass procedure for locally inoperable disease. Demographics, risk factors for postoperative complications and preoperative anaesthetic assessment data including P-POSSUM and Cardiopulmonary Exercise Testing (CPET) results were collected.

Results: 50 (33 male, 17 female) patients were included; median age 64 (39-79) years. The complication rate was 50% and the in-hospital mortality 4%. High P-POSSUM physiology score and low Anaerobic Threshold at CPET were significantly associated with postoperative complications (p=0.005, p=0.016 respectively). Overall long-term survival was significantly shorter in patients with postoperative complications (9 vs 18 months) and postoperative complications were independently associated with poorer long-term survival (p=0.003, OR 3.261).

Conclusions: These findings question whether a palliative bypass should be performed in patients with a high P-POSSUM physiology score or low CPET score due to the high complication rate and poor long-term outcome.

0341: LONG TERM OUTCOMES AFTER PERCUTANEOUS CHOLECYSTOSTOMY FOR ACUTE CHOLECYSTITIS - A MULTI-INSTITUTIONAL REVIEW

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Aim: To analyze the long-term outcomes after Percutaneous Cholecystostomy (PC).

Methods: Retrospective study of all consecutive patients who underwent PC at two university hospitals between 2000–2010.

Results: 53 patients underwent PC. 58% were ASA III and 34% ASA IV. The median duration of symptoms was 1 day (range 1-35). 63%(33/53) had calculous cholecystitis, whilst 37%(20/53) had acalculous cholecystitis. 7%(4/53) had gallbladder perforation. 82%(43/53) had USS-guided drainage while 18% had CT-guided drainage. The median time to PC from admission was 3 days (range 1-15). The median hospital stay was 15 days (range 7-120). 13%(7/53) patients developed complications including bile leaks(n =5), haemorrhage(n =1) and duodenal fistula(n =1). The in-hospital mortality was 18%. 34%(18/53) of patients eventually had cholecystectomy. 4/18 were done on the index admission and a majority had interval cholecystectomy (78%). 6/18 (33%) had laparoscopic cholecystectomy and a majority required conversion to open (67%). 22%(11/53) patients were readmitted with recurrent cholecystitis during follow-up. 13/53(24%) had repeated PC. The median time to representation was 151 days (2-510).

Conclusions: Only a minority of patients undergoing PC proceed to cholecystectomy. The risk of conversion to open procedure is high and should be emphasized during the consent. A quarter of patients present with recurrent cholecystitis requiring a repeat PC during follow-up.

0379: PROSPECTIVE AUDIT ON THE MANAGEMENT OF BILIARY PANCREATITIS

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Aims: The British Society of Gastroenterology (BSG) guidelines state that definitive management of biliary pancreatitis should be achieved within a 2 week period. The aims of our audit were to assess the management of patients with biliary pancreatitis.

Methods: Data was obtained prospectively from all consecutive patients presenting with acute biliary pancreatitis over a nine month period at two district general hospitals within our Health Board.

Results: Between September 2010 to May 2011 there were 52 admissions with acute biliary pancreatitis. 34 were females. Median age 62 years (range 18-97). Median Length of stay was 6 days (range 1-28). 3 patients died (5.7%). 7 patients underwent Endoscopic Retrograde Cholangiopancreatography (ERCP), with a median wait of 6 days (range 1-12 days). For 4 of these patients, ERCP was deemed as their definitive management due to co-morbidities. 35 patients underwent cholecystectomy, with only 13 of those having surgery within 2 weeks of diagnosis. Median wait from diagnosis to surgery was 23 days (range 2-260). We experienced an 11.1% readmission rate for those that did not undergo definitive management of their gallstones within 2 weeks.

Conclusion: There is significant morbidity associated with delayed definitive management of gallstones in those patients with biliary pancreatitis.

0403: COMPLIANCE WITH BSG GUIDELINES IN BILIARY PANCREATITIS IN A LARGE TEACHING HOSPITAL

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Aim: BSG guidelines state: 1) All patients presenting with severe biliary pancreatitis should undergo ERCP and sphincterotomy within 72 hours of onset of pain; 2) Patients with biliary pancreatitis should receive definitive treatment during the same admission, or within two weeks of discharge. This study aimed to determine compliance with BSG guidance on biliary pancreatitis in a large teaching hospital.

Methods: Retrospective analysis was conducted on all (19) patients admitted to the surgical unit with biliary pancreatitis over 6 months (Dec 2010-July 2011).

Results: Pancreatitis was graded severe in 9 (47%) patients and mild in 10 (53%) patients. Six (32%) patients underwent ERCP, none complying with BSG guidelines. Five (26%) patients underwent definitive treatment, 4 (21%) meeting BSG guidelines. There was one mortality in our cohort.

Conclusion: Compliance with BSG guidelines was extremely poor. All patients in our series waited longer than 72 hours for ERCP and 85% waited longer than two weeks for definitive treatment. Indeed, most patients (70%) waited longer than six months for laparoscopic cholecystectomy. Evidence shows that these patients are at significant risk of further episodes of acute pancreatitis, which may be life threatening. We must direct resources toward ensuring adequate access to emergency ERCP and expedited surgical treatment.

0599: THOROUGH PRE-OPERATIVE ASSESSMENT MUST BE CARRIED OUT PRIOR TO LAPAROSCOPIC CHOLECYSTECTOMY

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Aims: Up to 20% of patients who have undergone cholecystectomy continue to experience symptoms. Our aim was to identify the symptoms for which laparoscopic cholecystectomies (LC) were carried out and then determine the prevalence and the nature of persistent symptoms following the procedure.

Method: A validated pre-operative symptoms survey was completed at the time of listing of 500 consecutive LC, followed by a follow up phone survey 12 weeks post-operatively to record the nature, severity and frequency of symptoms experienced.

Results: All patients had at least 2 symptoms pre-operatively and 337 (67.4%) had 3 or more. The most common symptoms pre-operatively were abdominal pain (93.8%) and nausea (65.8%). A total of 90 patients were symptomatic postoperatively. Eighty one patients (16.2%) complained of abdominal pain, while 63 (12.6%) patients also experienced associated dyspeptic symptoms. Sixty patients underwent further investigation following LC; 36 patients went on to have a secondary diagnosis made, the most common (13/36) being hiatus hernia.

Conclusions: A significant number of patients continue to experience symptoms following LC. A careful biliary history, focused physical examination and a thorough pre-operative assessment must be carried out prior to LC to rule out conditions that masquerade as gallbladder disease.

0615: IS ULTRASOUND ALL WE NEED? A REVIEW OF BILIARY IMAGING AT FRENCHAY HOSPITAL

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Aim: Modern management of symptomatic gallstones needs to be streamlined with appropriate investigations and early intervention. We reviewed biliary radiology for emergencies admitted with suspected gallstone disease, assessing the efficiency of our radiology service.

Methods: A retrospective review was conducted of all acute surgical admissions to Frenchay in September 2011. Radiology records were obtained from ICE and WebPACS for patients referred as: right upper quadrant pain, jaundice or pancreatitis. Patients without gallstones or those not needing imaging were excluded.

Results: 43 admissions met the referral criteria, 36 of which were suitable for review. 34 ultrasound scans (US) and 13 MRCP were requested. Of weekday USS requests, 93% were scanned and 85% reported within 24 hours. 43% of weekend USS were performed and reported within 24 hours of request. 24% of USS were deemed inadequate mainly due to poor CBD views. 44% of inpatient MRCP requests were reported within 5 days with only 1 of 13 adding new information from USS.

Discussion: This study highlights the efficiency of our weekday USS service. MRCP introduced significant delays and added little diagnostic information. The increasing use of intraoperative imaging compensates for discrepancies in USS and may render MRCP redundant in the emergency management of gallstones.

0784: DO LIVER FUNCTION TESTS OR MRI FINDINGS PREDICT COAGULOPATHY IN OBSTRUCTIVE JAUNDICE?

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Aims: Clotting abnormalities in obstructive jaundice are well documented but it is unclear which patients are most likely to be at risk. This study aims to investigate possible predictive factors of coagulopathies in obstructive jaundice.

Methods: Patients undergoing Magnetic Resonance Cholangiopancreatography (MRCP) between March and August 2010 were identified retrospectively. The relationship of serum bilirubin, alkaline phosphatase (ALP), aspartate transaminase (AST) and common bile duct diameter to clotting was investigated.

Results: 72 patients were included. 9.7% had an INR of 1.3 or greater. The mean bilirubin was 90µg/L, mean ALP was 269µL and the mean INR was 1.17. CBD diameter ranged from 5-22.5mm with a mean of 10mm. There was no significant correlation of any parameters to INR.

Conclusion: None of the factors investigated predict the likelihood of coagulopathy in obstructive jaundice. Clotting impairment in jaundice is complex and multifactorial, making it difficult to identify patients at risk of bleeding complications. Our results fail to justify the routine administration of vitamin K in all jaundiced patients. We suggest that all patients should have coagulation studies performed but vitamin K should be reserved for those with abnormal results.

0823: ANALYSIS OF ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHIC (ERCP) MANAGEMENT OF COMMON BILE DUCT STONES IN THE LAPAROSCOPIC ERA

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Aims: Common bile duct stones (CBDs) are frequent. Current management trends are to perform laparoscopic cholecystectomy and therapeutic endoscopic retrograde cholangiopancreatography (ERCP) separately, necessitating co-operation of surgeons and gastroenterologists.