THE NUMBER OF INSTABILITY MARKERS IS A SIGNIFICANT PREDICTOR OF OUTCOME IN DISTAL RADIAL FRACTURES AND CAN BE USED AS A GUIDE TO DEVISE A STANDARDISED MANAGEMENT STRATEGY FOR THESE FRACTURES

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Background: Distal radial fractures are extremely common. An effective treatment strategy ensures good outcome and resource usage.

Aim: To identify the significance of the number of instability markers in distal radial fractures in predicting outcome and proposing a standardised management strategy.

Methods: Data was collected retrospectively over three months. Relevant instability markers identified through a literature review were: age >60, dorsal angulation >20°, intra-articular fracture, ulna fracture, dorsal comminution, radial shortening and osteoporosis. Each patient had number of instability markers, management and outcome recorded. Outcomes were graded as “good” or “poor” based on complications, function achieved and length of follow-up required.

Results: 119/207 patients had = 3 instability markers (Group A) and 88/207 had = 4 (Group B). In Group A, 91% achieved “good” outcome regardless of treatment type, versus 66% in Group B (p<0.001). In Group B, amongst patients who had surgery (29), 79% achieved “good” outcome, however those with manipulation alone (38), only 58% achieved “good” outcome (p = 0.03).

Conclusion: = 4 instability markers give a poorer outcome. Patients with = 4 markers did better with surgery than manipulation alone. However, non-operative management yields equally good results in patients with = 3 markers. This is a pilot study for future primary research.

HETEROGENEITY IN RANDOMISED CLINICAL TRIALS OF ENDOVENUOUS INTERVENTIONS FOR VARICOSE VEINS

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Aims: Efficacy of endovenous treatments for venous reflux has been demonstrated in numerous randomised clinical trials, although significant heterogeneity may exist between studies. We aimed to evaluate and compare outcome measures and reporting of randomised trials investigating varicose vein interventions.

Methods: Pubmed, Cochrane and Google Scholar databases were systematically searched. Randomised clinical trials published between January 1966 and June 2009 evaluating endovenous interventions for varicose veins were included. Published study reports were evaluated against the 2007 American Venous Forum recommended reporting standards.

Results: Twenty-eight randomised trials fulfilled inclusion criteria. Twenty of the 28 trials reported outcome measures. Outcomes were graded as number of instability markers, management and outcome recorded.

Conclusions: The association of surgeons in training.

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length of stay for patients discharged from ICU was 33 days (range 8–767 days). Closure of laparostomy was inversely related to death (p = 0.001), but death did not significantly correlate with faecal peritonitis.

TEMPORAL LOBE ABSCESSES AND THE ROLE OF ENT: A 10-YEAR REVIEW

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Background: Temporal lobe abscess carries a 10% mortality and up to 50% of patients suffer persistent seizures. Management lacks consistency, with only isolated case reports available. Chronic otitis media and mastoiditis are recognised risk factors but the value of adjuvant ENT surgery remains unknown.

Objectives: To determine the role of peri-operative mastoid drainage or mastoidectomy in reducing neurological re-operative rates and outcome.

Methods: A single centre, retrospective audit from 1999-2009. Microbiologically proven temporal lobe abscesses that underwent neurosurgery were included. Data collected included neurosurgical procedure, radiological findings pre- and post-operatively, organism(s) isolated, ENT procedure and timing, neurological re-operation rate and outcome.

Results: 26 patients were identified that met our inclusion criteria. All patients had antibiotic therapy. Radiological evidence of middle ear or mastoid involvement was reported prior to surgery in most patients. Some patients underwent ENT procedures. A number of patients underwent repeat neurosurgery. Statistical significance was determined using Chi-square testing. Preliminary results show patients that underwent adjuvant ENT surgery had lower re-operation rates and better outcomes.

Conclusions: This review will be the first audit to determine the role of adjuvant ENT surgery in the management of temporal lobe abscesses with co-existing middle ear or mastoid infection.

PSYCHIATRIC SERVICES TO THE PLASTIC SURGERY UNIT ARE NOT AN EPITOME

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Introduction: Plastic surgery trauma units (PSTUs) will be involved in many cases that need joint psychiatric care. There isn’t a standard framework in place for joint plastic and psychiatric services. We aim to assess the satisfaction of the psychiatric services on the PSTU across the UK.

Methods: PSTUs in the UK were identified using BAPRAS website. Each unit was enquired relating to the psychiatric input to the patients care. The unit satisfaction with the psychiatric input was noted and the whether there was specific funding in place for joint services.

Results: Twenty-eight randomised trials fulfilled inclusion criteria. Median patient age (reported in 20/28 studies) ranged from 33-54 years. 31 different outcome measures were utilised including 13 different questionnaires, varicose vein recurrence at 38 time points and 30 categories of complications. Duplex ultrasonography was used in 21/28 trials to assess recurrence. Quality of life was only evaluated in 11 studies and follow-up periods ranged from 3 weeks to 10 years.

Conclusions: Meaningful comparison across randomised studies of endovenous treatments is made difficult by considerable variations in study populations and outcome measures between trials. This highlights the need for the use of prospectively agreed population selection, and reporting standards for outcome measures in randomised clinical assessments of new treatments.
Conclusion: The psychiatric liaison received by PSTUs is inadequate. There are insufficient guidelines available and units around the UK are not satisfied with the methods of care. We propose specific guidelines, which are economical and will improve the service relationship of the psychiatric and plastic surgery team.

MANAGEMENT OF NON-SPINAL INJURY PRESSURE SORE REFERRALS

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Introduction: Pressure sores confer significant costs and can be troublesome to heal completely. There are many treatments yet the evidence is limited by the heterogeneous nature of the wounds and the patients’ morbidities. A previous review had identified pressure sore referrals as a significant contributing factor to the department’s workload. This review aimed to document the management strategies in non-spinal pressure sore patients and streamline their management.

Methods: 190 faxed referrals to 5 consultants were identified and retrospectively reviewed of the notes were undertaken. 24% (n = 46) patients were identified as non-spinal injury pressure sore referrals.

Results: 84% (n = 37) of pressure sores were managed using either bedside debridement or conservative treatment with dressings. Two patients had negative pressure dressing applied after ward debridement. The remaining patients (n = 7) had formal surgical debridement. 52% of patients referred eventually died and this often reflects the significant co-morbidities that are established before the pressure sore formation.

Conclusion: Non-spinal injury pressure sores can largely be managed conservatively and with supportive advice for the referring team. In a significant proportion of patients we can endeavour to manage these patients using simple, cost-effective wound care measures and the patients can be involved in the suggested management.

RISKS OF LIVER RESECTION IN A TERTIARY REFERRAL CENTRE


Introduction: Hepatic resection is a potentially curative procedure for patients with primary liver carcinoma or colorectal metastases. However, it is associated with significant morbidity and mortality, and these patients are susceptible to postoperative liver failure, infection and death.

Aims: This study aims to establish the risks and complications of liver resection in a UK tertiary referral centre.

Methods: Data was collected from all patients undergoing liver resection over a two year period at the Royal Infirmary of Edinburgh. Data was stored in an Access database and analysed using SPSS.

Results: Data was collected on 177 hepatic resections performed during the period studied (from total of 191). The median age was 61 years (range 19-84). The indications for resection were: colorectal cancer metastases 107; hepatocellular carcinoma 23; cholangiocarcinoma 10; benign lesions 19; and other conditions 18. 73 patients received preoperative chemotherapy, and 52% of procedures were major hepatic resections. Median length of stay was 6 days (range 2-58). 58 patients developed postoperative complications (32.8%). In hospital mortality rate was 3.4% (6 patients).

Discussion: In our tertiary referral centre, the complication and in-hospital mortality rates are comparable with those in the literature.

EMERGENCY ABSCESSES: REDUCING LENGTH OF STAY

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Aims: To reduce length of inpatient stay for patients undergoing emergency incision and drainage of superficial abscesses by introducing a new policy whereby surgery is performed as an urgent day case. Well patients were discharged from Casualty having been pre-assessed, marked and consented. The following morning they were readmitted and prioritised on the emergency list.

Methods: Retrospective study examining length of inpatient stay for patients undergoing emergency incision and drainage, for abscesses before and after policy implementation, from January 2005 to June 2006.

Results: There were 33 patients prior to policy implementation and 49 patients after. The mean total length of inpatient stay was significantly reduced from 26.8 hours to 15.5 hours (p = 0.002). The median number of nights in hospital was reduced from 1 to 0.

Conclusion: Policy implementation significantly reduced length of inpatient stay. Our experience following implementation of the policy was that patients preferred the new system. Extrapolation of our data (saving 65 bed days in a year) would equate to cost savings of approximately £20,000 per annum.

AN AUDIT OF CLINICAL CODING AND PCT CHARGES FOR PATIENTS’ TREATMENT AT A BUSY PLASTIC SURGERY REGIONAL UNIT

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Introduction: In the current era of foundation trusts and payments per results it is important to ensure adequate clinical coding of patients’ episodes.

Patients and Methods: We audited the coding of 100 patients treated by one consultant over a period of 30 days during 2008 at the department of Plastic Surgery at Lancashire Teaching Hospital NHS trust. Collected data was analysed and cost was calculated using the Department of Health reference books and cost calculating databases.

Results: 11 cases were miss-coded. Total payment calculated by the coding department was £115,809 compared to £115,739 during this study. The revenue from elective cases was £68,667 (average £980.95 per case) and trauma cases was £47,142 (average £1157.40 per case), burns £5065 (average £2532.50 per case), GA cases £48,399 and LA cases £58,009. We found no difference in payment if procedures are performed under local or general anaesthetic, if a single or multiple procedures are conducted and no codes available for free flaps.

Conclusion: There was 89% accuracy of coding of plastic surgery procedures at our trust. Difficulties in coding were mainly related to microsurgery cases. Day case trauma, local anaesthetic procedures and minor burns seem to be an important source of revenue.

TIME DELAYS IN DEFINITIVE TREATMENT FOR POLYTRAUMA PATIENTS TREATED IN THE ROYAL VICTORIA HOSPITAL, BELFAST, N. IRELAND

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