Conclusions: Negative laparotomies are reducing but slowly. It is important for institutions such as those in rural South Africa to invest in surgical expertise to be able to select appropriate cases for exploratory laparotomy and therefore reduce patient morbidity and reduce hospital costs.

Upper gastrointestinal surgery

0018: CHRONIC NEUROPATHIC PAIN POST THORACOTOMY FOR IVOR LEVIS OESOPHAGECTOMY
Introduction: Chronic pain post thoracotomy is a well-recognised problem following oesophagectomy due to various aspects related to the incisions location and may theoretically involve a neuropathic component due to compression of intercostal nerves under the rib spreader. Reported incidence has varied [11%-80%] with various surgical and anaesthetic techniques being used over the years, as a tertiary referral centre which performs 100 oesophagectomies a year we conducted this study to establish incidence in contemporary practice and assess whether or not a neuropathic component was involved.
Methods: Detailed phone questionnaires using PAINDETECT assessment tool were conducted with 43 oesophagectomy patients a year following their surgery.
Results: Incidence of chronic pain was reported at 56%, the majority of patients had at least 1 neuropathic feature in their pain descriptors, but only 4% fulfilled all criteria for neuropathic pain. Only 50% of sufferers were receiving pain treatment of any sort.
Conclusions: Current day practice is still associated with a high incidence of chronic pain, however only a minority of patients fulfil the criteria for neuropathic pain bringing into question our assumptions about the nature of this pain. Long-term pain management should be reviewed and audited as a service quality indicator.

0023: OUTCOMES OF LAPAROSCOPIC FUNDOPLICATION WITH THE USE OF A-MESH IN PATIENTS WITH GORD OR LARGE SYMPTOMATIC HIA-L TERNIAS
Michelle Christoudoulou*, Sarah Hassan, Paul Sutton, Joseph Varghese. Royal Bolton Hospital NHS Foundation Trust, Bolton, UK.
Introduction: Since 2011 in cases where we have identified a large hiatus hernia during Laparoscopic fundoplication, the hiatal repair was augmented with biosynthetic mesh (Gore Bio-A®). With this audit we aimed to establish the impact of the addition of mesh on symptomatic outcomes.
Methods: All Laparoscopic fundoplication’s performed between October 2011 and January 2013 by a single surgeon were included. The data were collected retrospectively and patient outcomes (GORD-HRQL quality of life questionnaire) were obtained both pre and post-operatively.
Conclusions: No significant difference in outcomes was found in patients who had had mesh augmentation compared to those who had not. The incidence of dysphagia was reduced in the mesh group (9% vs 30%). The mesh group had a significantly shorter hospital stay (3 days vs 5 days), and a significantly shorter follow-up period (16 months vs 43 months).

0191: VENOUS THROMBOEMBOLISM RISK IN GASTRIC CANCER PATIENTS
Ruth Graham*, Joy Singh. Glangwili General Hospital, Carmarthen, UK.
Introduction: To re-audit the management of acute pancreatitis against VTE and that this risk increases further with chemotherapy.
Methods: CANSCC database was used to identify patients diagnosed with Gastric Cancer from 2008-2012. Clinical portal allowed identification of patients who had follow-up CT scans and those who were diagnosed with Pulmonary Embolism (PE) or Deep vein thrombosis (DVT). The Health Board chemotherapy database was used to identify treatment regimes.
Results: Of the 157 patients identified, 103 went on to have treatment and 62 had follow-up CT scans. 53 patients had chemotherapy, 15 in association with surgery and 3 with endoscopic treatment. 31 patients had surgery and 19 endoscopic treatment only. A total of 5 PEs and 8 DVTs were identified. PEs were noted in patients who had surgery and chemotherapy (3,20%) and chemotherapy alone (2, 77%). DVTs were identified in patients who had no treatment (2, 3,7%), chemotherapy alone (2, 5,7%) and surgery alone (4, 12,9%).
Conclusions: Patients with Gastric Cancer have a higher risk of PE/DVT than the general population. Our results suggest around 1/5 patients who have surgery and chemotherapy will have a PE. We recommend VTE prophylaxis during treatment.

0194: BARIATRIC SURGERY PRODUCES SIGNIFICANT AND SUSTAINED REDUCTION IN POLYPHARMACY DEPENDENCY IN OBESE PATIENTS – A RETROSPECTIVE REVIEW OF POST-OPERATIVE OUTCOMES IN NHS LOTHIAN
Stefanie Chua*, Laura Arthur, Andrew de Beaux, Bruce Tulloh, Peter Lamb. University of Edinburgh, UK. "Department of General and Upper GI surgery, Royal Infirmary of Edinburgh, UK.
Introduction: To evaluate medication dependency, prescription costs, weight and BMI for patients pre- and post-bariatric surgery in NHS Lothian.
Methods: 140 patients who underwent 162 procedures from November 2003 - March 2012 were identified from a prospectively maintained departmental database. Data was collated from case notes and electronic records review. Weight, height and prescription drugs pre- and post-operatively at yearly intervals were recorded where available up to 4 years post-surgery. Drug pricing was sourced from www.bnf.org. Follow-up data was complete for 54 patients who were included in this analysis. Paired t-tests were calculated in SPSS v.19 with significance set at p<0.05.
Results: The number of obesity-related drugs taken daily decreased significantly at 1-year post-surgery from 3.3±2.6 to 1.6±1.8; p=0.000. This reduction in medication use was sustained at yearly intervals until 4 years post-surgery. There was significant reduction in drug costs pre-operatively; mean £541.94, and 1-year post-operatively; mean £234.75, p=0.002. Reduced drug costs were sustained at yearly intervals up to 4 years. Weight decreased significantly: pre-operative mean 140.78kg, 1-year post-operative mean 106.55kg, p=0.000. Weight loss was significant and sustained across 4 years.
Conclusions: Bariatric surgery produced significant weight loss with associated sustained reduction in obesity-related medication dependency and cost.