Notes. Areas reviewed included time from admission to imaging/operation and histology. A diagnosis of appendicitis was confirmed by histology. **Result**: DL for suspected appendicitis was performed in 108 patients; with 15% (n=16) having pre-operative ultrasound (US) and 14% (n=15) Computed Tomography (CT). Appendicitis was correctly diagnosed on US in 6.3% (1/16) and 100% on CT. One patient had a normal US, however histology demonstrated appendicitis. Only 50% diagnosed with appendicitis on US were proven histologically. In 81.3% (13/16) the appendix was histology demonstrated appendicitis. Only 50% diagnosed with appendicitis on US, but of these, appendicitis was proven in 38.5% (5/13). Time to operation was longer if US was performed (p<0.05), but showed no difference if CT was performed.

**Conclusion**: In patients requiring DL for possible acute appendicitis, US delays the time until operation and does not significantly alter management. These patients should be considered for an immediate CT or DL.

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1183: PERFORATED DUODENAL ULCER: POST-OPERATIVE OUTCOMES IN A UK DISTRICT HOSPITAL. A 10-YEAR RETROSPECTIVE REVIEW

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Aim: There is scarce recent literature on the outcomes of perforated duodenal ulcer (PDU) surgery in the UK. A recent meta-analysis notes a mortality of 10 - 25%.

**Method**: Analysis of 10 years of PDU surgery was performed using a prospectively maintained database and retrospective analysis of case notes. Patient demographics were noted, along with co-morbidity scoring using Charlson scoring and ASA grading. Post-operative morbidity was quantified with Clavien-Dindo (C-D) scoring.

**Result**: Between 1/5/2005 and 1/5/2015, 82 patients (62m, 20f) had surgery, median age 51.5y (21 - 88). 49% were admitted to HDU/ITU post-operatively. The 30-day mortality was 10.9%. Patients aged >70y had significantly higher mortality, 3.4% vs. 30.4% (p=0.01, OR 15.2 [2.9 - 79.2]). 65% of patients had no post-op morbidity (C-D 1). This group were significantly younger than those with morbidity (mean 43 vs 61, p=0.004) and had lower Charlson scores (1.8 vs. 3.2 p=0.004) and ASA grades (1.7 vs. 2.9 p=0.001).

**Conclusion**: This mortality figure of 10.9% is lower than reported. This may be because half our patients were admitted to HDU/ITU post-operatively and a result of quality routine post-operative care. These results justify aggressive surgery in the younger patient (>70y). This work may help determine “acceptable” mortality outcomes.

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1204: MANAGEMENT AND OUTCOMES OF APPENDECTOMY WORLDWIDE


**Introduction**: Appendicitis is the most common abdominal surgical emergency worldwide. The aim of this study was to identify variation in management and outcomes of appendicitis across high, middle and low tertiles of the Human Development Index (HDI).

**Method**: Patients in the GlobalSurg 1 study undergoing emergency surgery for appendicitis were eligible for inclusion in this study. Multilevel logistic regression identified associations with post-operative outcomes, while accounting for centre and country clustering. Simulation methods explored potential benefits of a laparoscopic approach.

**Discussion**: 4546 patients underwent emergency appendectomy (2499 high, 1540 middle and 507 low HDI tertiles). There was a significant increase in superficial site infection (SSI) between tertiles (14.8% low, 12% middle, 4.4% high, p<0.001), but no major complication (3.6% low, 2.8% middle, 3.2% high, p=0.634). Use of laparoscopy differed between low (8.1%) and high (67.7%) HDI tertiles and was associated with fewer major complications (OR 0.64, 0.41-0.98, p=0.039) and SSIs (OR 0.23, 0.15-0.35, p<0.001). The absolute risk reduction for SSI gained from laparoscopy was greater in low (7.0%) than high (3.5%) HDI countries.

**Conclusion**: Adverse outcomes following appendicectomy are unequally distributed across countries despite adjustment. A greater benefit may be conferred by laparoscopic surgery in lower income countries.

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1234: INCIDENCE OF COLORECTAL NEOPLASIA AFTER CT-CONFIRMED DIVERTICULITIS – YES TO COLONOSCOPY. NO TO FLEXIBLE SIGMOIDOSCOPY


Aim: The utility of endoscopic evaluation following admission with diverticulitis is unclear. NICE suggests evaluation following all hospital admissions. There is further uncertainty whether colonoscopy or flexible sigmoidoscopy is preferred. This study assesses the rate of colonic neoplasia detection following admission with CT-proven diverticulitis in a large DGH.

**Method**: Single-centre retrospective study from 2010-2015. Data included potential of complicated or uncomplicated diverticulitis, endoscopic evaluation and adenoma/cancer detection rate. Data were analysed using Chi-squared test.

**Result**: 6863 patients with diverticular disease were identified. 470 had CT-confirmed diverticulitis (125, 26.6% and 345, 73.4%) complicated and uncomplicated diverticulitis respectively. Patients with perforated diverticular disease were excluded. Median age was 60yrs (26 - 100y). Male: female ratio was 2: 3.322 patients underwent endoscopy (112 flexible sigmoidoscopy, 210 colonoscopy). Three cases of malignancy were identified (0.9%). Overall polyp detection rate was 23.9%. Colonoscopy was superior to flexible sigmoidoscopy (28.6% vs 13.9%). Polyp detection was similar after complicated and uncomplicated diverticulitis (13% vs 18%). Cancer incidence was not influenced by complicated diverticulitis (0.8% vs 0.6%, p=0.79).

**Conclusion**: The incidence of colorectal malignancy after hospital admission for diverticulitis is <1%. However, there is significant incidence of premalignant polyps. Although lower than the detection rate seen in the NHS bowel screening programme, it is still higher than the recent national (non-screening) aspirational adenoma detection rate of 20%. Endoscopic evaluation has utility and should not be performed via colonoscopy and not by flexible sigmoidoscopy. Our data do not support an association between complicated diverticulitis and neoplasia.

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1273: AHEAD OF THE CURVE: IMPLEMENTATION OF THE FIRST TWENTY-FOUR HOUR ACUTE SURGICAL ASSESSMENT UNIT (ASAU) IN IRELAND


**Background**: An Acute Surgical Assessment Unit (ASAU) was established in St Luke’s Hospital in July 2014. Emergency presentations, fitting SAU criteria, are referred directly to the surgical service. Senior decisions are made early in the patient service pathway by a dedicated consultant surgeon who has been relieved of their elective commitments.

**Aim**: To review the experience of an initial twelve month period of the first 24 hour SAU in Ireland.

**Method**: Data analysis was obtained from a prospectively maintained database between November 2014 to November 2015.

**Result**: During the study period, 5550 patients were reviewed in the ASAU, 49% of whom were admitted, 41% were discharged and 6% appropriately referred to other onsite services. A median waiting time of 34 minutes was achieved (range 0 – 353 minutes) and 69% of patients were seen within one hour of arrival. There were 428 emergency surgical procedures carried out with 82% being performed between 9am-6pm.

**Conclusion**: With the introduction of an ASAU, the majority of patients are assessed by the surgical service within 60 minutes. This has led to a significantly reduced burden on the Emergency Department and its...