

**Methods:** Retrospective data for 100 elective TURBT performed in a non-day case setting between December 2012 and June 2013 was collected. Demographic data as well as preoperative tumour assessment, histology, first or recurrent surgery, total resected and length of stay was recorded.

**Results:** 43% of patients were discharged within 24 hours, increasing to 77% at 48 hours. Identifiable preoperative factors such as tumour size affected hospital stay. With mean larger resections in those admitted longer. (>48hrs 11.35g versus <48hrs 4.22g). First diagnosis, higher tumour grade at histology and increasing age also affected admission.

**Conclusions:** There is a strong case for day case TURBT. Prolonged stay is often unavoidable, but predictable in the preoperative setting. As a result current practice in our department has changed; those identified as suitable pre-operatively undergo their TURBT as a day case. Re-audit is planned.

#### 0240: HIGH-GRADE (G3/CIS) NON-MUSCLE INVASIVE BLADDER CANCER: WHAT IS THE RISK OF BCG TREATMENT?

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**Introduction:** High-grade (G3/CIS) non-muscle invasive (NMI) bladder cancer (BCa) has a significant risk of progression to muscle-invasive BCa. BCG or early cystectomy is the treatment option for these tumours. This study aims to determine the risk of BCG bladder-preserving therapy.

**Methods:** A retrospective analysis was performed on patients who underwent BCG or radical cystectomy for G3/CIS NMI BCa in our centre between Jan-1 2008 and Jan-1 2013. Our cancer database identified 319 new BCa.

**Results:** Sixty-eight patients, median (IQR) age of 72 (65–82) years had G3/CIS NMI BCa. Sixty-one received BCG, 7 underwent early cystectomy. During a median follow-up of 26 (13–46.5) months, 24/68 (35.3%) patients had recurrent disease: BCG group n=21/61 (34.4%), 3 patients proceeded to cystectomy; cystectomy group n=3/7 (42.9%), p=0.69. Two (3.3%) patients in the BCG group had a 2<sup>nd</sup> recurrence (one underwent cystectomy). Ten deaths occurred: BCG group n=8/57 (14%); cystectomy group n=2/11 (18.2%) p=0.66. The Disease-Specific-Mortality (DSM) was: BCG n=7/57 (12.3%); cystectomy 1/11 (9.1%), p=1.00.

**Conclusions:** Following solely BCG treatment for G3 NMI BCa, 49/57 (86%) patients are alive, 40/57 (70.2%) are disease-free. The risk of recurrence requiring cystectomy following initial BCG is 4/61 (6.6%). BCG offers bladder-preserving treatment with a 70.2% disease-free survival.

#### 0253: DOES 3-DIMENSIONAL (3D) VISION IN LAPAROSCOPIC PYELOPLASTY IMPROVE OPERATING TIME COMPARED TO 2D-LAPAROSCOPIC PYELOPLASTY?

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**Introduction:** One of the difficulties in laparoscopic reconstructive surgery is adaptation to a 2-Dimensional flat view of the surgical field and the lack of depth perception which makes needle handling and suturing challenging. This study aimed to determine whether the use of 3D-Visualisation Systems in laparoscopic pyeloplasty improves operative time. We also reviewed intra operative morbidity compared to 2D.

**Methods:** Data were collected retrospectively from all patients that underwent a 3D-Laparoscopic Pyeloplasty and operative times and complications were compared to historical data from previous 2D-Pyeloplasties performed in our department.

**Results:** In the last 10 months we have performed 8 3D-Pyeloplasties. Mean operating time was 147 min (range 97–205 min) in 3D and 163 min (109–233 min) in 2D-Pyeloplasties. The longest two 3D procedures were performed by a supervised trainee. Excluding those two cases, 3D laparoscopic pyeloplasty time was 28 min shorter compared to 2D. There were no significant intraoperative complications.

**Conclusions:** 3D laparoscopy improves the perception of depth increasing the precision of suturing and reducing operating times. It can therefore augment laparoscopic skills and improve the learning curve for laparoscopic surgery. 3D Vision has a place in Laparoscopy Pyeloplasty today and a further evaluation of long-term operative outcomes is needed.

#### 0272: ASSESSING AND IMPROVING THE QUALITY OF DOCUMENTATION SURROUNDING URINARY CATHETER INSERTION

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**Introduction:** Accurate documentation of urinary catheter insertion is an important legal record and point of reference. We sought to audit the quality of catheter documentation at West Middlesex University Hospital, then improve documentation and patient care.

**Methods:** The notes of all adult inpatients with urinary catheters inserted during their hospital stay were retrospectively reviewed. Catheter documentation, in either the medical or nursing notes, was compared against 10 EAUN guidelines<sup>1</sup>. A catheter pro-forma sticker was designed, publicised and implemented and the audit repeated.

**Results:** 48 catheter insertions were included in the initial audit. Only 63.22% of the guidelines set out by EAUN were recorded accurately in either set of notes. Identity of 'catheteriser'(58%), indication(56%), description of urine(8%) and residual volume(60%) were particularly poorly documented. 32 Catheter insertions were included for re-audit, when overall adherence to EAUN guidelines was 74.67%. The uptake of the pro-forma sticker was low but when used, documentation was 96.3% complete.

**Conclusions:** Documentation surrounding catheter insertion in our trust is inadequate. Using a catheter insertion pro-forma sticker saves time and improves quality of documentation. Further work is required to improve the uptake of this documentation tool, which may be usefully implemented in other hospital trusts.

#### 0292: THE IMPACT OF AN OPERATIVE NOTE PROFORMA ON OPERATION NOTE STANDARDS IN A DISTRICT GENERAL UROLOGY DEPARTMENT

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**Introduction:** Our aim was to ascertain if operative notes within a district general urology department adhered to Good Surgical Practice (Royal College of Surgeons of England 2008) guidelines.

**Method:** We prospectively audited 100 urological operations performed within the hospital and reviewed the operation notes against RCS guidelines. Following the initial audit, we designed and introduced a paper based operative note proforma; a re-audit of 100 operations was then undertaken.

**Results:** Initial results showed that compliance with certain fields was very weak and that all areas could be improved. At re-audit all data criteria standards were either maintained or improved. Prior to the proforma, time and complications were only documented in 4% and 10% of operation notes respectively. Following the proforma introduction this rose to 70% and 74% respectively. The mean percentage data point inclusion rose from 67.2% to 91.8%.

**Conclusions:** This closed loop audit cycle presents evidence that the use of an operative note proforma led to significant improvements in operative note standards within this urology department. A further re-audit must be undertaken to ensure that these initial improvements are not simply transient following the introduction of the proforma.

#### 0319: INITIAL INVESTIGATION OF RENAL COLIC IN A DGH

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**Introduction:** To assess timeliness of appropriate investigation of patients presenting with symptoms of urolithiasis. As per BAUS guidelines. Review of patients who were confirmed as having urolithiasis and assess whether acute admission could have been avoided.

**Methods:** All CTUs requested for suspected renal colic over a period of 6 months were reviewed. Patients who were previously known to have urolithiasis were excluded. The notes were then reviewed to determine diagnosis on discharge, intervention undertaken and if serum calcium and urate measurements were undertaken.

**Results:** Total number of CTU's requested for eligible patients 81. Total number of new stone positive CTU's 30 (37%). Number of patients diagnosed with renal colic 43. 13 patients had negative CTUs with evidence of recent stone passage. Mean overall wait for CT 30.85 hrs. Mean weekday wait 27.4 hours. Mean weekend wait 40.0hrs. 9 of 30 stone positive patients required intervention during the acute admission.

**Conclusions:** Admission on a weekend increases the likelihood of a prolonged wait for imaging and prolonged hospital stay. The main reason for admission was diagnostic uncertainty, whilst awaiting CTU. The majority of patients confirmed as having urolithiasis did not require acute intervention. Expedited imaging from A&E may reduce acute admissions.