

group 63% of patients had an amputation of any kind. There were six (16%) major amputations in the SIRS positive group compared to two (3%) major amputations in the SIRS negative group. This difference was significant ($p=0.038$, Fisher's exact test).

Conclusions: The SIRS score may be a useful indicator of the risk of major amputation in patients admitted with diabetic foot infection.

0230: DOES SOCIOECONOMIC STATUS PREDICT OUTCOMES FOLLOWING CAROTID SURGERY?

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Introduction: To determine the influence of socioeconomic status (SES) on complication and mortality rates following carotid endarterectomy (CE).

Methods: A retrospective review was carried out of all patients undergoing a CE in our trust between 2007 and 2013. The Index of Multiple Deprivation Score (IMDS) was used as a surrogate for the SES of each patient. A lower IMDS indicates a higher SES. Data was gathered relating to patient demographics, co-morbidities, NASCET grade of carotid disease, post-operative complications and 30-day mortality.

Results: 300 patients were identified and divided into 3 groups, with group 1 comprising those with the highest SES (median IMDS 15.05) and group 3 comprising those with the lowest (median IMDS 30.93). There was no difference in the prevalence of diabetes mellitus, ischaemic heart disease or peripheral vascular disease between groups 1 and 3. There was no difference in post-operative complication rate ($p=0.301$) or 30-day mortality ($p=0.683$). Although there was no difference in the NASCET grade of ipsilateral stenosis between groups 1 and 3 ($p=0.257$), group 3 had significantly higher NASCET grade of contralateral disease ($p=0.027$).

Conclusions: SES has no influence on outcomes following CE. However, socioeconomic deprivation is associated with a greater severity of contralateral carotid disease.

0242: ABDOMINAL AORTIC ANEURYSMS: IS THE PRESSURE ON?

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Introduction: Studies have implied that periods of low atmospheric pressure could be associated with an increased incidence of ruptured abdominal aortic aneurysms (rAAA). Decreased atmospheric pressure is thought to increase intra-mural tension predisposing to rAAA. Our aim was to determine if low atmospheric pressure influences rupture of AAA.

Methods: 131 patients with confirmed rAAA over a 10-year period were identified from retrospective hospital records. Daily pressure readings from the local meteorology station were obtained for the days on which ruptures occurred. The mean daily atmospheric pressure was calculated for the entire period of the study. Student's t-test was used for analysis.

Results: Mean atmospheric pressure from the days of rupture (1013.78mB) was lower than the mean daily pressure over the 10-year period (1014.73). However this did not attain statistical significance ($p = 0.1237$).

Conclusions: Our study does not demonstrate a significant relationship between atmospheric pressure and rAAA. This contradicts previous reports that suggest a significant association between low atmospheric pressure and the incidence of AAA rupture.

0255: IS A GAP BETWEEN PERCEIVED AND ACTUAL PRACTICE IN INFORMED CONSENT FOR ELECTIVE AAA REPAIR: AN EXAMPLE OF A WIDER PROBLEM IN SURGICAL PRACTICE?

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Introduction: This study compares self-reported perceived, versus actual practice in consent for elective AAA repair, and explores possible causes for observed differences and the potential impact on wider surgical practice.

Methods: A retrospective audit of 36 elective AAA repairs (21 EVAR, 15 open) was performed, together with a prospective questionnaire of 17 clinicians comparing reported and actual practice against the 2012 VSGBI Guidelines. Chi-squared analysis was performed to assess the significance of observed differences.

Results: No consent form included all complications (mean 7.4/16, range 4–13/16). There was a statistically significant difference between reported and actual performance in consent ($p<0.0001$). Statistically significant differences were also seen for specific domains: risk of doing nothing ($p<0.0001$), myocardial infarction ($p<0.0001$), stroke ($p<0.0001$), chest infection ($p<0.0001$), paraplegia ($p=0.0032$), death ($p=0.0076$).

Conclusions: There is a statistically significant difference between actual and reported practice for AAA repair consent, with significant differences observed in 6/16 specific domains. Potential explanations for this include a failure to document all discussions held, e.g. risk of doing nothing; reluctance to confront difficult issues, e.g. death or myocardial infarction; forgetting to document all the issues discussed. This observed difference in consenting practice should be highlighted as relevant and important to all surgical specialties.

0256: ROUTINE PELVIC MAGNETIC RESONANCE VENOGRAPHY IN DUPLEX-CONFIRMED LOWER LIMB VENOUS REFLUX OF A SUSPECTED PELVIC ORIGIN DOES NOT CHANGE CLINICAL MANAGEMENT

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Introduction: To investigate whether the diagnosis and management of symptomatic lower limb varicose veins is influenced by MR venography (MRV) when a pelvic source of incompetence is suspected.

Methods: 51 patients with symptomatic lower limb varicose veins, with suspicion of a pelvic source on duplex ultrasound in the absence of symptoms of pelvic congestion syndrome underwent direct contrast enhanced pelvic MRV.

Results: 51 patients (94.1% female, mean age 43.8yrs, 31.2% recurrent vs. 68.8% primary) were studied. 78 legs were imaged with duplex. 7 had a negative duplex, 71 a positive duplex (18 supra-inguinal reflux, 14 superficial vein incompetence with pelvic reflux, 39 mixed incompetence). 36(70.6%) of MRV's were normal; 11(21.6%) equivocal and 4(7.8%) positive with a pelvic source of incompetence identified. 82.6% of patients who underwent a surgical intervention had their surgery delayed by MRV imaging.

Conclusions: A small proportion of patients with a suspected pelvic source of venous incompetence had a positive pelvic MRV, showing that unlike in patients with pelvic congestion symptoms, MRV imaging with only duplex suspicion of pelvic incompetence rarely changes management and is of little diagnostic value. It is therefore not recommended in this cohort; reducing cost and resource utilisation, and speeding up definitive treatment.

0258: UNITED STATES NATIONAL SURVEY OF VASCULAR SURGERY CONSENT

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Introduction: The objective of this survey was to explore peer-practice relating to vascular surgery patient consent.

Methods: A prospective anonymous online survey was administered to members of the Society of Clinical Vascular Surgery. A 75% majority for a particular question was deemed the threshold for consensus opinion for that particular complication.

Results: 179/1210 members completed the survey (consultants=85.5%).- Fellows were competent to perform consent. The majority of patients are consented within twenty-four hours of surgery (43%), primarily by the attending themselves (67.6%) using a dedicated consent form. Consensus regarding general arterial complications included discussion of bleeding (94.9%), wound infection (90.4%), cardiac (94.9%), cerebrovascular (92.6%), respiratory (78.7%) and thromboembolic (76%) events. Venous complications included bleeding (86%), bruising (90%), thromboembolism events (87%), wound infections (81.8%) and scarring (77.8%). Open aortic aneurysm complications included anastomotic leak (89.8%), graft infection (89.8%), gut ischemia (82.8%), impotence (85.6%), lower limb ischemia (86.4%) and renal failure (88%). Carotid endarterectomy included cerebrovascular accident (97.2%), cranial nerve injury (93.5%), hoarseness (87.7%), patch infection (75%), re-stenosis (81.3%), speech (76.6%) and swallowing (82.2%) difficulties, wound hematoma (89.6%) and parasthesiae (75%). Peripheral arterial surgery included distal ischemia (94.1%), further surgery (90.1%), graft infection (91.1%) and occlusion (95%), limb oedema (81.2%) and loss (95%), nerve injury (79.2%), procedural failure (91.1%) and need for prosthetic graft (79%). Amputation surgery also required discussion of chronic pain (84%), failure to regain mobility (79.2%), joint contractures (74.3%), phantom pain (88.1%) and proximal amputation (91%). Varicose vein interventions included failure to improve symptoms (88.5%), further surgery (82.3%), hematoma (79.2%), nerve injury (82.3%) and parasthesiae (80.2%), recurrence (87.5%) and skin staining (86.5%). 37% and 5.8% of centres provided informal and formal consent training respectively.