

Results: 16 of 183 (8.7%) patients had increased LOS. Mean age was 74 y (SD+/-15y). Total LOS for the cohort was 366d (mean LOS 22d, SD+/-20d) and corrected LOS was 245d (mean 15.4d, SD+/-18.8d). Surgical Sepsis accounted for 143d, social service delays for 83d and intervention services delays for 18d. There was no significant difference for age between factors. Overall estimated annual extra bed cost was £661500.

Conclusion: Incidence of surgical sepsis and the efficiency of intervention services and social services should be targeted to reduce prolonged surgical LOS.

0201: OUTPATIENT FLUID AND ELECTROLYTE MANAGEMENT FOR PATIENTS WITH HIGH OUTPUT STOMAS AND ENTEROCUTANEOUS FISTULAE

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Aim: Fluid and electrolyte management for patients with high output stomas/enterocutaneous fistulae is challenging. Historically, their care required repeated admissions to avoid ongoing complications eg, acute renal failure. We report our experience of outpatient management of such patients led by a nutrition support team.

Method: A retrospective analysis of a prospectively maintained database was performed. All patients met their nutrition needs enterally. Patients attend a ward based clinic with facilities for monitoring (weight, fluid balance, diet, PICC line care, bloods, urinary sodium and medication review) and IV hydration and/or magnesium/potassium supplementation. Individual cases are discussed at a weekly nutrition support meeting.

Results: Between September 2009 - September 2012, 83 patients attended (male:female 43:40, median age 66, range 18-92). 73 had high output stomas, 11 had enterocutaneous fistulas. Total clinic days attended was 1239 (median 9 range 1-109 days). On 224 visits, IV fluids were administered, of which 95 were given IV magnesium and three, IV potassium. Eleven required admission (admission rate of 1%). Other outcomes were either optimisation for surgery, discharge without surgery or long term monitoring without inpatient stay.

Conclusion: Patients with complex fluid balance and electrolyte needs can be managed successfully in the outpatient setting.

0236: IS LAPAROSCOPIC SURGERY FOR RIGHT HEMICOLECTOMY COST-EFFECTIVE?

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Aim: To compare oncological outcomes and cost of laparoscopic and open surgery for right hemicolectomy.

Methods: Patients who had a right hemicolectomy from January to November 2011 were identified from a prospectively maintained database of operations. Oncological outcomes were recorded and costs of surgery were calculated by costing each item of equipment used for each case.

Results: There were 44 patients (28 men (64%); median age 72.8 years (range, 18.4-89.2)). Thirty-two patients (73%) had elective surgery. Thirty patients (68%) had a laparoscopic operation (3 converted). Of the 17 open cases, 8 (47%) were acute cases as compared to 4 emergency cases out of 27 laparoscopic cases (15%, $P=0.019$). Primary pathology was cancer in 37 patients (84%). There were no differences between laparoscopic and open surgery in surgical time (181 minutes vs. 134 minutes [open], $P=0.593$), resected nodes (18 vs. 16, $P=0.968$), distance to nearest longitudinal margin (65 cms vs. 75 cms, $P=0.078$) or inpatient stay (7 vs. 8, $P=0.681$). Laparoscopic surgery was significantly more expensive (£1014 vs. £439, $P=0.032$).

Conclusions: Laparoscopic surgery for right hemicolectomy is associated with equivalent oncological adequacy but is considerably more expensive than open surgery. This may be important in healthcare planning with future financial constraints.

0238: "ASSESSMENT OF ACCURACY IN PREDICTING SITE OF COLORECTAL CANCER AT ENDOSCOPY"

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Aim: Colorectal cancer is the third most common cancer in the UK with endoscopy playing an important role in the bowel screening programme. Site of cancer will determine type of surgery and any further investigation.

This audit was undertaken to assess our accuracy in predicting site of cancer.

Method: A central database was used to identify cases. Specific site of cancer was compared against documented site at endoscopy, using a standard of $\geq 90\%$ accuracy, as proposed by JAG (Joint Advisory Group on GI Endoscopy).

Results: 357 cases were identified from 2011/12, and 315 included. 233 tumours (74%) were accurately sited. Most sited incorrectly were of little significance, however within the rectal cancer group ($n=108$), 7 were deemed recto-sigmoid and 8 sigmoid. Only 67% of rectal tumours had distance from anal margin documented.

Conclusion: Accuracy was below standard which in part may be due to poor documentation. There is confusion, particularly around rectal tumours, but this group is of high importance as mistakes could delay imaging (MRI) and treatment. This highlights a potential pothole and it is vital that endoscopists have an understanding of anatomy and its surgical relevance. We will address our findings at re-audit.

0252: THE USE OF ORAL IRON SUPPLEMENTATION AT DISCHARGE FOLLOWING COLORECTAL CANCER RESECTION - WE COULD DO BETTER

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Aims: Iron-deficiency is common following colorectal cancer (CRC) resection. For those who require adjuvant chemotherapy, pre-existing anaemia increases the risk of requiring blood transfusion. We aimed to assess current provisions of post-operative oral iron supplementation (Fe^{++}).

Methods: In 2011, we undertook a single-centre retrospective study of patients undergoing potentially-curative CRC resections. Demographic, haematological, histological and therapeutic data was retrieved. Follow-up haematological data was obtained for a cohort of patients who re-attended for adjuvant chemotherapy.

Results: 118 patients were identified, 61 patients were anaemic on admission and 83 on discharge, of whom 46 had $Hb < 10g/dL$. Seven (8%) of the anaemic patients had Fe^{++} prescribed at discharge. 32 patients received adjuvant chemotherapy, of these 24 (75%) were anaemic at discharge of whom 16 (67%) remained anaemic at the start of chemotherapy. The mean haemoglobin rise between discharge and commencing chemotherapy was $2.1g/dL$ (SD 0.57) with Fe^{++} versus $1.6g/dL$ (SD 1.33) without. Three patients, all with untreated anaemia required blood transfusion during chemotherapy.

Conclusions: A majority of patients are anaemic following resectional surgery for CRC. Treatment at discharge was inadequate at the study centre. Fe^{++} may improve restoration of normal haemoglobin prior to adjuvant chemotherapy with the potential to reduce transfusion requirement.

0387: ASIT-DUKES' CLUB/ACPGBI PRIZE WINNER: CT VIRTUAL COLONOSCOPY (CTVC) AND THE USE OF IV HYOSCINE BUTYLBROMIDE

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Aims: To assess the effect of IV Hyoscine butylbromide (Buscopan) on luminal distension for CT virtual colonoscopy (CTVC).

Methods: Over 4 months patients were randomly selected and given 20mg of Buscopan intravenously before undergoing CTVC. These scans were compared to a set of randomly selected control scans where Buscopan had not been administered.

Using the same grading system as Taylor et al, a GI radiology consultant graded all of the images. The colon was divided into 6 segments (Caecum, Ascending, Transverse, Descending, Sigmoid, Rectum) and each was graded from 0 (collapsed colon) to 3 (excellent distension, folds $< 2mm$) in supine and prone positions.

Results: There were 46 patients in total (23 per group). The Buscopan group showed improved distension in all segments of colon. There was a 50% increase in the number of 3's scored in the ascending and descending colon images, 30% for transverse and 20% for rectum and sigmoid. Caecal imaging had a high rate of 3 scores in both groups. Overall 86% of Buscopan images scored 3 compared to 54% of non-Buscopan.

Conclusions: The use of IV Buscopan improves colonic distension for CTVC providing better imaging. This may help avoid repeat investigations.