0670: HOW SAFE IS 23-HOUR STAY THYROID SURGERY?
M. Walls*, A. Popovic, L. Hemmer, K. Haigh, I. Eckersall, W. Elsaiy. James Cook University Hospital, UK

Aim: 23 hr stay surgery for primary hemithyroidectomy has been shown to be safe practice. We present our experience of 23 hr stay hemithyroidectomy and see if this can be extrapolated to completion and total thyroidectomies.

Methods: All thyroid surgery between 01/07/2013 and 01/08/2014 was identified and electronic records searched for key variables including pathology and post operative blood results.

Results: Discharge rates for ≤23 hr/≤24 hr/beyond 1700 post operative day 1 are as follows: hemithyroidectomies - 96%/46%/94% with no readmissions within 60 days, completion - 0%/6.7%/33.3% with no readmissions, total thyroidectomies - 2.4%/2.4%/14.3% with one readmission due to acute kidney injury (2.4%).

Conclusion: 23-hour stay is safe and our department standard. Timings of electronic discharge may introduce errors into length-of-stay data eg generic 0000 admission/ discharge times. We saw no complications requiring readmission/hospital assessment in hemi or completion groups and 2.4% readmissions in the total thyroidectomy group within 60 days. One (2.4%) total thyroidectomy patient had post-operative calcium levels <2mmol/L. No airway-related complications were seen in any group. From our data and supported in the literature, sub-23 hr total thyroidectomy is possible and safe but severe and time critical complications can present a mental barrier to adoption of this practice.

0674: EARLY POSTOPERATIVE MANAGEMENT FOLLOWING TOTAL THYROIDECTOMY: AUDIT CYCLE
O. Wakelam*, A. Michael, G. Mochlouls. Lister Hospital, UK

Aim: The British association of Otorhinolaryngology Head and Neck Surgery recommend that following total thyroidectomy all patients receive hormone replacement and have calcium levels checked within 24 hours. The British association of Endocrine and Thyroid Surgeons recommend that all patients undergoing thyroid surgery should have a post-operative vocal cord check. We aim to evaluate our early postoperative management following total thyroidectomy against these national guidelines.

Methods: All patients undergoing total thyroidectomy at Lister Hospital over six months were included in the initial audit. Thyroid hormone replacement, calcium checks and vocal cord checks were verified using patient medical records. The re-audit was conducted in the subsequent six months following the introduction of a postoperative proforma.

Results: 19 patients were included in the initial audit and 16 patients in the re-audit. All patients received thyroid hormone replacement and calcium checks. Vocal cord checks were performed on 17 patients (89%) in the initial audit and 15 patients (94%) in the re-audit.

Conclusion: The use of a postoperative proforma following total thyroidectomy increased the rate of vocal cord checks. Routine vocal cord checks would facilitate more accurate measurement of recurrent laryngeal nerve palsy rates, and more reliably allow comparison between surgeons with respect to this outcome measure.

0983: LEVEL VI NECK DISSECTION IN PAPILLARY CANCER: DIAGNOSTIC YIELD AND EFFECT ON SURVIVAL
L. Alcock*, D. Kamali, W. Elsaiy. James Cook University Hospital, UK

Aim: It is our experience that the presence of central nodal metastasis is under reported on ultrasound scan (US) in papillary thyroid cancer. We report our diagnostic yield of central nodal metastasis following central neck dissection, complications and any effect on survival benefit.

Methods: Single centre, single surgeon retrospective review of all patients with a histological diagnosis of papillary thyroid cancer who underwent total thyroidectomy over a thirty month period (2011–2013). Pre-operative US and post-operative histology results were compared.

Results: 14 cases, (mean 44 years/12:2 M:F) of which 12 (86%) had proven metastasis. US findings were suggestive of clear metastatic lymphadenopathy in 11 (79%) patients. Following US, 3 (21%) cases required further invasive procedures. 2 (14%) with indeterminate US features of lateral disease underwent intraoperative frozen section and were found to be negative, the remainder a misdiagnosed dermoid cyst underwent total thyroidectomy and lateral dissection following nodal excision biopsy. US sensitivity 79% (CI 49 – 95%), PPV 84% (55–98%). One recorded mortality 24 months following surgery.

Conclusion: US is a useful tool in identifying patients who have lateral lymphatic changes secondary to metastatic papillary thyroid cancer. However in patients where US proves inconclusive, further investigations should be considered to reduce the risk of unnecessary surgery.