of endoscopy-related oral mucosal injuries was 31.6% (24/76). Of these, 21 were recorded from the wet gauze subgroup, and 3 from dental dam. The comparative mucosal injuries rate for wet gauze and dental dam was 37.5% (21/56) and 15.3% (3/20) respectively. No teeth trauma recorded.

**Conclusions:** Alveolar ridge mucosal and gingival injuries remain a significant complication during rigid endoscopies. The routinely used wet gauzes appear inadequate in providing optimal protection. With the newly devised appliance, the dental dam may provide an alternative for oral protection during rigid endoscopies, although further studies are required.

1247: BALANCE WORKSHOP: SYNCHRONIZED HEAD AND FORCE PLATE MEASUREMENTS. THE POTENTIAL FOR DIAGNOSTIC YIELDS

Cian O. Hughes, David D. Pothiser, Paul Ranalli, John A. Rutka. Toronto General Hospital, Toronto, ON, Canada.

**Introduction:** Currently only force-plate measurements are used in posturography. Given that the vestibular end-organs are situated within the temporal bone, recording movement of the head can provide additional information compared to body sway alone. We describe the synchronously recording of head position during posturography and investigate its potential additional value.

**Methods:** A device was designed to capture information from head-mounted accelerometers and gyroscopes, allowing movements and position to be accurately measured in three dimensions. Ten normal participants, ten patients with bilateral vestibular loss (BVL) and ten patients who were instructed to mangle were tested using the modified clinical test of sensory interaction on balance (mCTSIB).

**Results:** Our device accurately synchronized with the force-plate and allowed sway data to be calculated for the head. Normal controls showed a strong correlation between head and foot measurements: path length mean r-score = 0.57 (p < 0.001). This correlation became negative in BVL patients (mean r-score = -0.48 (p < 0.001)).

**Conclusions:** This study suggests that head data are related to footplate data, but in pathologic conditions also provide different information from which diagnoses can be made. Given the small size of the device, it has the potential to be used over long periods. This allows for the telemetry of longitudinal data on sway.

1255: A PROSPECTIVE AUDIT OF CHRONIC RHINOSINUSITIS (CRS) MANAGEMENT AT A TEACHING HOSPITAL: BEFORE AND AFTER THE 2012 EUROPEAN POSITION PAPER GUIDELINES ON CHRONIC RHINOSINUSITIS (EPOS)

Lulu Ritchie, Anna Slovick, Shilpy Ojha, Romana Kuchai. St Marys Hospital, London, UK.

**Introduction:** If maximal medical treatment fails for CRS, EPOS recommends performance of a CT sinus scan to demonstrate the extent of disease; surgical intervention may then be considered.1 We prospectively investigate adherence with EPOS guidelines for CRS management at a teaching hospital, to maximise medical therapy and minimise unnecessary CT scans requests.

**Method:** Adult referrals with suspected CRS were recorded retrospectively before (n = 38, 6months 2012) and prospectively after (n = 28, 6months 2013) the implementation of departmental EPOS-based CRS management algorithm and education. Data collected included: medications prescribed, days from presentation to CT scan and to surgery, and surgical cancellations due to sub-maximal therapy.

**Results:** 28% of patients before and 20% after the implementation of EPOS guidelines were given sub-maximal medication prior to surgery, resulting in fewer cancellations on the day of surgery. Time from presentation to CT scan improved from 73 to 132 days due to prior maximisation of medical therapy.

**Conclusions:** Our algorithm demonstrated improved maximal medical treatment and CT scan requesting prior to surgery and resulting surgical cancellations. Further education and re-auditing will ensure continued reduction in radiation exposure and timely surgical intervention.

1279: THE USE OF TRACHEOSTOMIES IN OBESIVE PATIENT UNDERGOING TONSILLECTOMIES: A CASE SERIES

Helen Turner, Tom Mawby, Mridula Rai. Oxford University Hospitals NHS Trust, Oxford, UK.

**Introduction:** To evaluate past practice in the John Radcliffe Hospital in Oxford, a tertiary ENT referral centre. To learn from past experience to make tonsillectomy in the obese and morbidly obese as safe as possible. It is though that in the event of a post tonsillectomy bleed, it would be incredibly difficult to re-intubate a bleeding obese patient. Therefore, a tracheostomy would provide a safe alternative airway. There is no current guidance for airway management in obese patients requiring tonsillectomy.

**Methods:** The theatre database logging the last 50000 operations identified suitable patients. Inclusion criteria comprised of; tonsillectomy and tracheostomy performed on the same admission and obese or morbidly obese. We excluded patients who were having a tonsillectomy as part of a head and neck resection for cancer.

**Results:** Six patients were identified. The main indication for tonsillectomy in this group of patients was obstructive sleep apnoea. There were no fatalities. Complications were seen from both the tonsillectomy and the tracheostomy, some life changing. We will discuss our recommendations based on our past experience.

**Conclusions:** Obese patients undergoing tonsillectomy should be considered for a tracheostomy. Guidelines are needed on the subject.