Conclusion: The psychiatric liaison received by PSTUs is inadequate. There are insufficient guidelines available and units around the UK are not satisfied with the methods of care. We propose specific guidelines, which are economical and will improve the service relationship of the psychiatric and plastic surgery team.

MANAGEMENT OF NON-SPINAL INJURY PRESSURE SORE REFERRALS

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Introduction: Pressure sores confer significant costs and can be troublesome to heal completely. There are many treatments yet the evidence is limited by the heterogeneous nature of the wounds and the patients' morbidities. A previous review had identified pressure sore referrals as a significant contributing factor to the department's workload. This review aimed to document the management strategies in non-spinal pressure sore patients and streamline their management.

Methods: 190 faxed referrals to 5 consultants were identified and retrospective review of the notes was undertaken. 24% (n = 46) patients were identified as non-spinal injury pressure sore referrals.

Results: 84% (n = 37) of pressure sores were managed using either bedside debridement or conservative treatment with dressings. Two patients had negative pressure dressing applied after ward debridement. The remaining patients (n = 7) had formal surgical debridement. 52% of patients referred eventually died and this often reflects the significant co-morbidities that are established before the pressure sore formation.

Conclusion: Non-spinal injury pressure sores can largely be managed conservatively and with supportive advice for the referring team. In a significant proportion of patients we can endeavour to manage these patients using simple, cost-effective wound care measures and the patients can be involved in the suggested management.

RISKS OF LIVER RESECTION IN A TERTIARY REFERRAL CENTRE


Introduction: Hepatic resection is a potentially curative procedure for patients with primary liver carcinoma or colorectal metastases. However, it is associated with significant morbidity and mortality, and these patients are susceptible to postoperative liver failure, infection and death.

Aims: This study aims to establish the risks and complications of liver resection in a UK tertiary referral centre.

Methods: Data was collected from all patients undergoing liver resection over a two year period at the Royal Infirmary of Edinburgh. Data was stored in an Access database and analysed using SPSS.

Results: Data was collected on 177 hepatic resections performed during the period studied (from total of 191). The median age was 61 years (range 19-84). The indications for resection were: colorectal cancer metastases 107; hepatocellular carcinoma 23; cholangiocarcinoma 10; benign lesions 19; and other conditions 18. 73 patients received preoperative chemotherapy, and 52% of procedures were major hepatic resections. Median length of stay was 6 days (range 2-58); 58 patients developed postoperative complications (32.8%). In hospital mortality rate was 3.4% (6 patients).

Discussion: In our tertiary referral centre, the complication and in-hospital mortality rates are comparable with those in the literature.

EMERGENCY ABSCESSES: REDUCING LENGTH OF STAY

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Aims: To reduce length of inpatient stay for patients undergoing emergency incision and drainage of superficial abscesses by introducing a new policy whereby surgery is performed as an urgent day case. Well patients were discharged from Casualty having been pre-assessed, marked and consented. The following morning they were readmitted and prioritised on the emergency list.

Methods: Retrospective study examining length of inpatient stay for patients undergoing emergency incision and drainage, for abscesses before and after policy implementation, from January 2005 to June 2006.

Results: There were 33 patients prior to policy implementation and 49 patients after. The mean total length of inpatient stay was significantly reduced from 26.8 hours to 15.5 hours (p = 0.002). The median number of nights in hospital was reduced from 1 to 0.

Conclusion: Policy implementation significantly reduced length of inpatient stay. Our experience following implementation of the policy was that patients preferred the new system. Extrapolation of our data (saving 65 bed days in a year) would equate to cost savings of approximately £20,000 per annum.

AN AUDIT OF CLINICAL CODING AND PCT CHARGES FOR PATIENTS’ TREATMENT AT A BUSY PLASTIC SURGERY REGIONAL UNIT

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Introduction: In the current era of foundation trusts and payments per results it is important to ensure adequate clinical coding of patients’ episodes.

Patients and Methods: We audited the coding of 100 patients treated by one consultant over a period of 30 days during 2008 at the department of Plastic Surgery at Lancashire Teaching Hospital NHS trust. Collected data was analysed and cost was calculated using the Department of Health reference books and cost calculating databases.

Results: 11 cases were miss-coded. Total payment calculated by the coding department was £115,809 compared to £115,739 during this study. The revenue from elective cases was £68,667 (average £980.95 per case) and trauma cases was £47,142 (average £1571.40 per case), burns £5085 (average £2532.50 per case), GA cases £48,399 and LA cases £58,009. We found no difference in payment if procedures are performed under local or general anaesthetic, if a single or multiple procedures are conducted and no codes available for free flaps.

Conclusion: There was 89% accuracy of coding of plastic surgery procedures at our trust. Difficulties in coding were mainly related to microsurgery cases. Day case trauma, local anaesthetic procedures and minor burns seem to be an important source of revenue.

TIME DELAYS IN DEFINITIVE TREATMENT FOR POLYTRAUMA PATIENTS TREATED IN THE ROYAL VICTORIA HOSPITAL, BELFAST, N. IRELAND

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Background: ATLS guidelines advise early definitive care of trauma patients. This leads to shorter hospital and intensive care unit (ICU) stays and lower mortality. 9 district general hospitals serve Northern Ireland’s 1.8 million population with The Royal Victoria Hospital (RVH) Belfast being the region’s tertiary referral trauma centre. It was our perception that delays in early definitive care were occurring.

Methods and Patients: Using the Fractures Outcome Research Database, we analysed transfer times, collected prospectively, for multi-trauma patients admitted to the RVH from 2000-2008. Mechanism of injury and injuries sustained were used to describe the patient group. 546 patients were identified (121 Female, 425 Male). Age: <20 (23%), 20-30 (36%), 30-40 (25%), 40-50 (15%).

Results: 73% of multi-trauma patients were transferred to the RVH within 24 hrs of injury (mean 40.2 hrs, median 6.5 hrs, range 1hr-72hrs). 188/546 (35%) were admitted within 24 hrs of injury (mean 40.2 hrs, median 4.4 hrs, range 1hr-72hrs). 87% of multi-trauma patients requiring ICU are transferred within 24hrs (mean 29.8 hrs, median 6.5 hrs, range 1hr-72hrs). 116/546 (20%) were admitted directly to RVH; 116/546 (20%) were admitted to ICU. Mechanism of injury: Road traffic accidents 80.6%, falls 12.8%, crush injury 2.4%, gunshot injury 2%, miscellaneous 2.2%. Intensive care patient distribution of injury: Pelvic 42/116 (36%), Femoral shaft 57/116 (49.1%), Spine 64/116 (55.2%).

LOCALISATION OF INTRA-THYROIDAL PARATHYROID ADENOMA WITH SESTAMIBI SCANNING

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Background: Parathyroidectomy is the definitive treatment for primary hyperparathyroidism but accurate localisation of the affected gland is essential to cure. The need for localisation studies, and the optimal method, remain a matter of debate. Up to 10% of parathyroid glands may be ectopic and these cases represent an added operative challenge.

Method: We report a single centre experience of parathyroidectomy over 5 years ending 2008. Data was collected through retrospective casenote review.

Results: 51 patients underwent parathyroidectomy for primary (n = 50) or recurrent (n = 1) hyperparathyroidism. Average age was 61.3 years (range 34-81) and 6 patients were male. All patients underwent 99mTC-labelled sestamibi isotope scanning. In 42 cases (82%) sestamibi scanning correctly localised a functioning adenoma. In the 9 remaining cases, 8 adenomas were identified correctly at operation and one operative specimen was reported as normal parathyroid tissue. 4 of 51 patients had intrathyroidal adenomas, of which all were localised on sestamibi scanning but only one was visible at operation. In each case hemithyroidectomy was performed and histology confirmed removal of adenoma.

Discussion: In this series, routine preoperative sestamibi scanning enabled accurate localisation of intrathyroidal parathyroid adenoma. This method of pre-operative localisation enabled hemithyroidectomy to be confidently undertaken in all such cases.

ARE INFLAMMATORY MARKERS USEFUL IN ADULT APPENDICITIS?

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Aim: The diagnosis of appendicitis and decision to operate is based primarily on clinical assessment. However, white cell count (WCC) and C-reactive protein (CRP) are often measured in patients with suspected appendicitis. The aim of this study was to assess the importance of these markers for appendicitis.

Methods: Data was collected retrospectively on consecutive patients who underwent emergency appendicectomies at our institution over a one year period from November 2008. Preoperative WCC and CRP measurements were correlated with appendic histology.

Results: 174 appendicectomies were carried out during this period (male: female 64%: 36%, mean age 33). 134 (77%) patients had histologically-confirmed appendicitis, 27 (16%) normal appendices were removed. WCC and CRP were significantly raised in patients with appendicitis (normal vs appendicitis WCC 8.3 vs 14.1 p = 0.008, CRP 31 vs 123 p = 0.0001), 43% of appendices were gangrenous or perforated, with CRP significantly (p = 0.07) raised in these patients (CRP 83). WCC was also raised (14.7 vs 13.6, p = 0.25). 2 patients had appendicitis with both normal WCC and CRP levels.

Conclusion: WCC and CRP are raised in appendicitis. CRP levels can indicate disease severity. Patients with normal WCC and CRP levels are unlikely to have appendicitis, but the diagnosis cannot be excluded.

SAFETY AND FEASIBILITY OF LAPAROSCOPIC ANTERIOR RESECTION FOR COMPLICATED SIGMOID DIVERTICULAR DISEASE: A CASE SERIES

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Aims: Laparoscopic procedures for colorectal cancer are well established; however similar surgery for complicated diverticular disease is reputed to be more technically challenging and is associated with greater shorter term complications. The aim of this audit was to assess the safety and feasibility of minimal access surgery in these patients.

Method: The first thirty five consecutive patients undergoing laparoscopic anterior resection for complicated sigmoid diverticular disease were audited prospectively. Data recorded included patient demographics, duration of surgery, conversion rate, operative blood loss, length of stay and post operative complications, including in-patient mortality. Numerical results are presented as median and interquartile ranges (IQR).

Results: Of the 35 patients which underwent surgery (M: F of 9:26; median age of 66 years), 20 (57%) had had previous open abdominal operations. The median operating time was 177 minutes, with a median of 100 ml estimated blood loss. There were 4 (11%) conversions to open surgery. 5 (14%) patients developed postoperative complications but there were no immediate postoperative deaths. The median length of hospital stay was 4 days and there were 3 (9%) readmissions within 3 months.

Conclusions: These results attest to the safety and feasibility of laparoscopic surgical resection in complicated sigmoid diverticular disease.

SELF-EXPANDING METAL STENTING FOR MALIGNANT COLONIC TUMOURS: A PROSPECTIVE STUDY

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Background: Self-expanding metal stents (SEMS) have been used in the management of malignant colorectal obstruction for palliation or as a bridging tool to single-stage surgery. We present the clinical results of a series of patients with colonic cancer in whom SEMS were inserted endoscopically under radiological guidance.