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Background: The new national guideline from NHS improvement was to notify relevant team of known cancer patient being acutely admitted to hospitals providing acute oncological service. A new uro-oncology alert system by text and e-mail was set up at our District General Hospital accordingly.
Aim: To assess the time delay of notification of acute admission. To assess the quality of referrals and outcomes for urological cancers through the system
Methods: Prospective assessment of the 53 referrals through the alert system from October 2011 to January 2012.
Results: Of the 53, 32 patients had same day notification. Significant delay of more than 72 hours was in 3 patients. 19 of these were for urological cancer related admissions while 6 were for non urological cancers and the rest were for non cancer related events. 5 patients had urgent input in their care that has resulted in better outcomes.
Conclusion: About 10% of patients had averted a significant adverse outcome because of the alert. Delay in notification and false notifications are the problems of initial service setup and should be corrected at the patient inclusion level. Longer numbers are needed to ascertain if the alert system would bring about significantly better outcomes.

1150: CAN RENAL TUMOUR CHARACTERISTICS HELP US PREDICT TIME TO TUMOUR RECURRENCE?

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Aims: The incidence of renal carcinoma is increasing with more nephrectomies being performed. It has a high recurrence rate, with 20-30% developing metastases after nephrectomy; however information about time to recurrence is often lacking. The aim of this study was determine timescales of recurrence based on tumour characteristics.
Methods: Using our prospectively compiled database on radical nephrectomies, our analysis concentrated on the incidence and time to recurrence, and also tumour characteristics such as stage and grade.
Results: We had complete data for 205 patients.
For pT1 cancers (n = 60), the median time to recurrence was 38.5 months, for pT2 (n=41) 24 months and for pT3 (n=99) 13 months (p = 0.09). For low grade tumours (G1-2, n= 98), the median recurrence time was 42 months and for high grade tumours (G3-4, n = 106), it was 11 months, which was statistically significant (p=0.004).
Conclusions: This data shows that tumours with higher grade and stage are likely to recur earlier, and that higher grade tumours recur more often. This information should enable clinicians to counsel patients more accurately, and could be implemented into local diagnostic and follow-up protocols.

1153: DO INTRAVENOUS UROGRAMS STILL HAVE A ROLE IN INVESTIGATING RENAL COLIC? A PROSPECTIVE AUDIT OF PRACTICE IN A DGH

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Aims: BAUS and NICE guidelines recommend non-contrast CTKUB for diagnosing renal calculi. This is not always possible in district general hospitals, particularly out-of-hours. We audited imaging of suspected renal colic in a DGH.
Methods: Prospective audit of 61 patients with suspected renal colic. Data collected included initial and subsequent imaging and delays to definitive management.
Results: CTKUB was first-line imaging in 26 patients (42.6%), intravenous urogram (IVU) in 19 (31.1%), ultrasound scan in 11 (18%), and plain abdominal x-ray in 5 (8.2%). Of those investigated with IVU initially, 84% were performed outside of working hours (0900-1700). 40% of patients who did not have an initial CTKUB subsequently required this for definitive diagnosis. Mean delay between initial and subsequent imaging was >19 hours resulting in an extra night hospital stay for 9 patients, with approximate additional cost to the trust of £4,500.
Conclusions: CTKUB has a better specificity and sensitivity than IVU for diagnosing renal calculi. Unless clinically unwell, we recommend CTKUB as first-line in all cases of suspected renal colic, with planned re-attendance for definitive imaging if presenting out-of-hours. This should reduce additional radiation to patients, reduce delays in management and discharge, and provide additional cost-savings to the trust.

1211: BARRIERS TO DECISION MAKING IN CANCER MULTIDISCIPLINARY TEAMS. ANALYSIS OF CANCER DECISION-MAKING IN TWO SURGICAL SPECIALITIES

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Introduction: In the UK, the multidisciplinary setting has become the standard to discuss cancer cases, yet there is no agreed way to assess the efficacy of MDT meetings (MDMs). This study investigated the factors hampering decision-making in cancer MDMs.
Methods: All available MDT decision outcomes of cancer patients discussed between February to December 2012 of both Urology and colorectal surgery were reviewed. MDT decisions and reasons for cases with no decision reached were analysed.
Results: MDT discussion outcome of 2035 cancer cases were reviewed (19 Urology MDMs, n=1126, 50 Colorectal MDMs, n=909). 9.5%(n=107) of Urology and 6.4%(n=58) of colorectal cases had no decision reached. Main reasons were: unavailability of histopathological results (47.7%(n=51) of urology and 24.1%(n=14) of Colorectal cases); unavailability of radiological investigation results (43.9%(n=47) of Urology and 43.1%(n=25) of Colorectal cases); unavailability of an Oncologist in the meeting(3.7%(n=4) of Urology and 5.2%(n=3) of Colorectal cases).
Discussion: This study uncovers the main barriers that MDTs face in decision-making. Assessing the efficacy of a MDT could be made by its capability to formulate a decision plan for all the cases discussed. Tackling these barriers would result in a more cost-effective process, enhance decision-making and thus enhance cancer care.

1245: SURGICAL AND ONCOLOGICAL OUTCOMES FOLLOWING NEPHROURETERECTOMY IN THE MANAGEMENT OF UTTCC

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Aim: The oncological behaviour of upper urinary tract transitional cell carcinomas UTTCC is varied but more advanced disease is notoriously aggressive. We reviewed the surgical and oncological outcomes following open (ONU) and laparoscopic nephro-ureterectomy (LNU) in the treatment of UTTCC at our institution.
Methods: Medical records and departmental databases of patients undergoing NU between 2004 and 2011 were reviewed. Complications were recorded using the Clavien-Dindo classification.
Results: Sixty one patients with a minimum follow up of 12 months were included (median age 71 years). Fifty six (92%) patients had LNU. Thirteen patients (21%) had post-operative complications - 8 were Grade 1 and 5 were Grade 2. Histology confirmed 53 (87%) TCC tumours and 1 (1.5%) case had inoperable UTTCC disease. At median follow up of 32 months, 17 (32%) patients developed de-novo bladder TCC and 7 (13%) systemic recurrence. Overall and disease specific survival was 67% and 88% respectively. Despite 34 of 54 patients (63%) having G3 or ≥T2 disease, only 5 (9%) died of disseminated TCC and 13 (24%) died of other causes.
Conclusion: Our data is consistent with other similar large series' in the literature. Most deaths observed during follow-up were from competing causes rather than recurrent UTTCC.

1246: PAIN RELATED AND OVERALL MORBIDITY WITH TRUS GUIDED PROSTATE BIOPSY – A PROSPECTIVE STUDY

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Introduction: Assess analgesia requirement after trans-rectal ultrasound guided prostate biopsy ($TRUSB_x$) for appropriate counselling.
Materials and Methods: Prospectively, successive patients undergoing $TRUSB_x$ filled questionnaires. Sextant $TRUSB_x$ under peri-prostatic block (1% lidocaine) and antibiotic prophylaxis were performed. Pain perception was assessed using a Visual Analogue Score (VAS).
Results: Mean age of 405 patients was 67.5 years. Mean VAS during the procedure was 2.93 and 2.20 on reaching home. Mean maximum VAS for the cohort on day 1 and day 2 were 1.27 and 0.7 respectively. 140 (35%)