

identical to those with complex disease randomised to PCI in the SYNTAX trial (80.8%). This suggests that depending on clinical situation, either treatment can be justified.

0422: STAGED HYBRID PROCEDURE FOR THE MANAGEMENT OF EMERGENCY LEAKING TYPE A AORTIC DISSECTION

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Introduction: Acute Type A aortic dissection (ATAAD) is a surgical emergency with a high mortality. Procedures including a frozen elephant trunk have been suggested to manage them surgically. We describe our experience of a leaking ATAAD, which was managed successfully with a staged hybrid procedure (SHP) by a multidisciplinary team approach (MDT).

Methods: 78 years old man with leaking ATAAD underwent a 1st stage surgical replacement of his ascending aorta under deep hypothermic circulatory arrest with retrograde cerebral perfusion. Re-entry tear and site of the contained rupture were identified just distal to the origin of the left subclavian artery (LSA). This was not possible to repair through a median sternotomy. The Interventional Radiologist performed the 2nd stage procedure by stenting the leaking descending thoracic aneurysm with a Thoracic Endovascular Aortic Stent followed by Amplatzer device closure of his LSA to prevent an endoleak.

Results: SHP has made it possible to manage this complex ATAAD, which cannot be treated by conventional surgery alone. The patient made an excellent recovery with no neurological complications.

Conclusions: A multidisciplinary staged hybrid procedure provides an effective treatment for an acute Type A aortic dissection complicated by a contained rupture of the descending thoracic aorta.

0485: DOES PERI-OPERATIVE ANTI-COAGULATION IN THORACIC SURGERY ALTER THE RATE OF POST-OPERATIVE BLEEDING?

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Introduction: Patients undergoing thoracic surgery have a higher risk of developing veno-thromboembolism (VTE). There are currently no guidelines for the use of perioperative anticoagulation in thoracic surgery. We performed a prospective audit assessing the use of perioperative anticoagulation and its impact on postoperative bleeding.

Methods: Data for thoracic procedures was collected from drug charts, surgical database and notes. The fields included: type of surgery, VTE score, preoperative medications, use of perioperative anticoagulation, drain output at 6, 12 and 24 hours post procedure and reoperations.

Results: 78 patients with an average VTE score of 19 (>14 is high risk) thoracic surgery. 34 patients (Group A) received enoxaparin on post-operative day 0, however 44 patients (Group B) did not receive anticoagulation. The mean bleeding rates were 389ml and 444ml in group A and B respectively. During our audit period no patients were reopened for bleeding and there were no in hospital postoperative VTEs.

Conclusions: There was no trend towards increased bleeding in the group that received anticoagulation on the day of the operation. While keeping in mind the small sample size in this study, one could make a case for commencing anticoagulation on the night of the operation to reduce the incidence of postoperative VTEs.

0559: WHO SURGICAL SAFETY CHECKLIST COMPLIANCE AFTER CORONARY ARTERY BYPASS GRAFTING IN A LARGE TERTIARY CARE HOSPITAL

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Introduction: The WHO surgical safety checklist can prevent 40% of inadvertent deaths and prevent almost 29% of major complications when correctly adhered to. Failure to complete the checklist puts patient safety at risk and has large financial implications for NHS trusts.

Methods: We studied WHO checklist compliance for coronary artery bypass grafting (CABG) at the cardio-thoracic surgery department of Wythenshawe hospital. Advancing quality North West guidelines require 100% adherence with the WHO checklist. We completed the audit cycle and a third audit to ensure sustained improvement in practice.

Results: We assessed the WHO checklist of 70 consecutive CABG patients during the year 2013 and found 25% compliance. The loop-closure audit of 40 consecutive patients revealed 88% compliance. A third

prospective audit of 50 patients revealed 90% compliance with the WHO checklist.

Conclusions: The correct completion of the WHO checklist is the responsibility of the surgeon. However, through completion of 3 audits we observed over three-fold improvement in checklist completion when the entire theatre team was given the responsibility in ensuring its correct completion by surgeons. We recommend theatre team empowerment in ensuring the correct completion of the checklist as well as regular auditing as monitoring tool to assess checklist adherence.

0958: HOSPITAL STAYS POST CARDIAC SURGERY: WARFARIN VS DABIGATRAN

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Introduction: To compare the hospital stays of patients anticoagulated with warfarin versus dabigatran for the treatment of post-cardiac surgery atrial fibrillation (AF).

Method: All patients that developed new-onset AF following cardiac surgery in our hospital were identified, using data from the National Adult Cardiac Surgery Database. Patients that were not anticoagulant naïve or required anticoagulation for multiple reasons were excluded. The hospitals electronic prescribing system was used to calculate time between initiation of anticoagulation and discharge.

Results: 110 patients with AF post-cardiac surgery were identified. Of these, 63 (57%) reverted to sinus rhythm within 48 hours of surgery and therefore were not anticoagulated. 20 patients (18%) did not meet the aforementioned criteria and were therefore excluded.

27 patients met the criteria for comparison. Of these 20 (74%) were anticoagulated with Warfarin, and 7 (26%) with Dabigatran. The average hospital stay for patients' anticoagulated with Warfarin and Dabigatran was 3.5 and 2.7 days, respectively.

Conclusions: Anticoagulation with dabigatran results in shorter hospital stays. However, warfarin is still much more likely to be prescribed than dabigatran. This may be because doctors are not confident in prescribing this relatively new drug. More education is necessary in order to increase utilization of Dabigatran.

1173: PERIOPERATIVE ASPIRIN IN THORACIC SURGERY: AN AUDIT OF DOCUMENTATION AND USE

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Introduction: This audit aimed to identify current peri-operative use of aspirin in a regional thoracic surgery department and how clearly this is communicated to patients.

Methods: Patients taking aspirin admitted for elective thoracic surgery were identified from electronic records. Medical records and pre-operative clinic letter(s) were assessed to determine the indication for aspirin use, and whether a clear plan for its peri-operative use had been explained to the patient in writing. Inconsistencies between pre-operative letters from clinicians and pre-operative assessment clinic recommendations to the patient were identified.

Results: 41 patients were identified over a 4-month period. Overall, 74% of patients had no clear plan documented in pre-operative clinic letter(s). With the exception of those on dual therapy for coronary stents (100%), the documentation for high-risk patients was poor: Coronary stent (single agent – 20%); Secondary prevention of CVA/TIA (10%); Secondary prevention of MI (0%). There was also inconsistency in practice – 84% of patients (on single therapy) had aspirin stopped pre-operatively, including 40% of patients with coronary stents, contrary to current guidelines.

Conclusions: This audit revealed inconsistent documentation and peri-operative use of aspirin in the department. Further work to clarify appropriate aspirin use and improve written communication is ongoing.

1270: OUTCOMES OF THORACIC SURGICAL INTERVENTIONS ON ECMO PATIENTS: A 4 YEAR EXPERIENCE

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Introduction: Extra-corporeal-membrane-oxygenation (ECMO) is used in severe respiratory failure to maintain adequate gas exchange. These