Background: In concordance with the national guidelines, the St. Mark’s Hospital colonoscopy tattooing protocol stated that suspicious lesions should be tattooed, with the exception of those in the caecum and within 20 cm of the anal verge. Three tattoos should be placed (120° apart, close to the lesion) and distal to lesions proximal to the splenic flexure (SpFlx). Left-sided lesions should have tattoos placed proximal to the lesion.

Aims: To audit compliance with the tattooing protocol in patients undergoing surgery for colorectal neoplasia.

Methods: We reviewed endoscopy reports for the location of tattoos relative to the lesion and number of tattoos placed in all patients who had surgery over 12 months.

Results: 114 reports were available and full compliance with the protocol was observed in 71 cases (62%). 19 cases (17%) were partially compliant and 24 cases (21%) were non-compliant. Incomplete documentation was observed in 71 cases (62%). 19 cases (17%) were partially compliant with the protocol.

Conclusions: Educational intervention is necessary to address poor documentation. However, changes to our protocol are also required. The new protocol recommends that all tattoos should be placed distal to the lesion, regardless of the anatomical position.

0051: DOES RIGID SIGMOIDOSCOPY HAVE A PLACE IN THE MODERN OUTPATIENT COLORECTAL CLINIC?

Mouhamed E. El Sayad, Abidon Bamidele, Kawan Shalali, Emad Aly, Aberdeen Royal Infirmary, Aberdeen, UK

Background: Although flexible sigmoidoscopy is now used in most outpatient colorectal clinics, rigid sigmoidoscopy is still used in many other (OP) colorectal clinics. The aim of our study is to assess the efficacy of rigid sigmoidoscopy.

Methods: Retrospective review of 103 patients that attended OP Colorectal clinic who had undergone rigid sigmoidoscopy for colorectal symptoms. Findings as well as requirement of further investigation were recorded.

Results: 103 patients. Presenting symptoms were: change in bowel habit 47 (45.6%), PR bleeding 33 (32%), rectal mass 8 (7.8%), Abdominal pain 4 (3.8%), faecal incontinence 1 (0.9%), tenesmus 1 (0.9%), anaemia 1 (0.9%) and follow up patients 8 (7.8%). Finding were: normal mucosa 62 (60.1%), inflamed mucosa 5 (4.9%), rectal polyp 2 (1.9%) and uninformative 34 (33.1%). Of the 103 patients, 68 (66%) required further investigations. 35 (34%) did not require further investigation. Amongst those who had a normal finding, on further investigation 16 (25%) had different pathologies. 3 (42%) out of 7 patients whom had abnormal finding on rigid sigmoidoscopy, no abnormality was detected on further investigation.

Conclusions: Our study showed that rigid sigmoidoscopy was rarely useful in the OP clinic set up. Further investigations were almost always needed to complete the assessment of the patient.

0097: LYMPH NODE HARVEST IN COLORECTAL RESECTIONS: AN AUDIT AT A SOUTH-EAST ENGLAND COLORECTAL SURGERY UNIT COMPARING PERFORMANCE IN 2005 AND 2008 WITH ANALYSIS OF THE INFLUENCE OF KEY OPERATIVE FACTORS

Khabab Osman, Catherine Pringle, Humphrey Scott. Ashford & St Peter’s NHS Trust, Chertsey, Surrey, UK

Lymph node examination is vital in the staging of colorectal cancer and ultimately influencing decisions on post-operative management. The ‘Association of Coloproctology of Great Britain and Ireland’ as well as the ‘National Institute of Clinical Excellence’ recommend that at least 12 lymph nodes are examined per resection.

Aim: This study assesses the performance of a large colorectal surgery unit in England against the above targets between 2005 and 2008 with an analysis of the influence of operator and patient variables.

Method: A hospital database search was used to identify all patients who underwent colorectal cancer resections in the months of October in 2005 (n=51) and 2008 (n=69). Information was extracted manually from notes and computed.

Results: A significant improvement was shown in lymph node clearance from 8.2 to 11.0 between 2005 and 2008 respectively (p=0.0019). No statistically significant difference between elective/emergency or open/ laparoscopic resections was shown. The strongest improvement was found in open resections between 2005 & 2008 cohorts.

Conclusion: The results of the study provide further cause to explore and discuss the reasons behind the apparent improvement in lymph node harvest and to determine the relative importance of surgical technique, histopathological techniques and other possible influential factors.

0115: COLORECTAL RESECTIONS: EVALUATING SHORT TERM POSTOPERATIVE OUTCOMES IN LAPAROSCOPIC VERSUS OPEN SURGERY

Ee Von Woon, Prem Ruben Jayaram, Pete Chong. University of Glasgow, Glasgow, UK

Introduction: Laparoscopic colectomies has become increasingly popular in the recent decade, however reluctance still exists to widely apply it for colorectal resections. This study aims to evaluate the postoperative outcomes of laparoscopic surgery (LS) compared to open surgery (OS) in our centre.

Method: All patients who underwent colorectal resection from June 2010 to February 2011 were reviewed retrospectively from the hospital database. Parameters include length of postoperative stay, infective and non-infective complications.

Result: Between June 2010 and February 2011, a total of 99 patients of median age 69(range 20-95) underwent colorectal resection. The most common indication was malignancy (66%). 56/99 cases were subjected to LS, and 43/99 to OS, with a number of 5 conversions. Median postoperative stay was 13 days. This was higher in OS (10) compared to LS (7).

45 positive cultures occurred in 31 patients. OS has a significantly higher (p=0.01) incidence of infection - 20/43 (46.5%) patients compared to LS - 11/56 (19.6%).

Total non-infective complications was 29 (29.3%). This difference was not significant between OS (14, 48.3%) and LS (15, 51.7%).

Conclusion: LS demonstrated better postoperative outcomes compared to OS. As a result of this study, further reviews were conducted within the General Surgery department to explore the possibility of increasing usage of the laparoscopic method.

0118: THE ROLE OF FDG-PET CT IN COLORECTAL CANCER

Sadaf Jafferbhoy, Adam Chambers, James Mander, Hugh Paterson. Edinburgh Colorectal Unit, Edinburgh, UK

Background: There is limited evidence to support the use of PET-CT in colorectal cancer. The aim of this study is to evaluate the clinical impact of PET scan in management of our patients.

Methods: 1043 patients were identified from SCAN database over a 2 year period, from July 2009. 103 patients underwent a FGD-PET CT in addition to conventional imaging. In this retrospective study, PET CT findings were compared with CT findings and the clinical impact was evaluated.

Results: 27 patients (26.2%) had PET CT for pre-operative staging and 76 patients (73.7%) for disease surveillance. Based on PET findings, the management was altered in 21 (77.7%) patients in pre-operative group with indeterminate CT findings. In the follow-up group, PET had a significant impact on management of 51 patients (67.1%), of which 39 had indeterminate CT findings. 6 patients with a negative CT had recurrent disease and another 6 patients with resectable disease on CT had unresectable metastases on PET.

On the basis of PET CT, surgery was avoided in 32 cases (31%) and 32 patients (31%) were offered curative resection.

Conclusion: PET CT plays a significant role in management of colorectal cancer by avoiding unnecessary surgery or identifying recurrent disease at an early stage.

0161: AUDIT OF CT COLONOGRAPHY: DOES IT ANSWER OUR QUESTIONS?

Aaron Rooney, Ananth Vijendren, Marion Obichere. Luton and Dunstable NHS Foundation Trust, Bedfordshire, UK

Aim: CT Colonography (CTC) is being increasingly used instead of colonoscopy as it is less invasive and detects extra-colonic abnormalities. It has 94.5% sensitivity and 99.7% negative predictive value for colorectal cancer. As it is frequently used in our hospital, we aim to assess - appropriateness of requests; bowel preparation adequacy; effectiveness in identifying abnormalities; diagnostic value and possible use as a screening tool and/or gold standard investigation.

ABSTRACTS
**Methods:** All CTCs from 1.1.2011-31.7.2011 were identified. Data was collected on age, gender, responsible consultant, presenting complaint, bowel preparation, colonic and extra-colonic findings, other investigations and final diagnosis.

**Results:** Most of the 182 CTCs performed were requested by colorectal surgeons and gastroenterologists. A minority were unsuitably used to investigate anaemia and PR bleeding. Bowel preparation was adequate in 75% of CTCs, affecting diagnostic value in 3 cases. Colonic abnormalities were detected in 50% of cases, extra-colonic in 67% and diagnosis reached in 70%. It had 100% sensitivity and 50% specificity for colorectal cancers and 94% sensitivity for diverticular disease.

**Conclusion:** CTCs have high sensitivity and low specificity as evidenced by NICE. We have recommended it as a screening tool and have altered the bowel preparation guidelines, and online CTC request forms to improve efficacy.

**0179: A CASE SERIES OF ENCAPSULATING PERITONEAL SCLEROSIS - A SINGLE-CENTRE EXPERIENCE**

Robert Spence, Keith Gardiner. Royal Victoria Hospital, Belfast, Northern Ireland, UK

**Aim:** Encapsulating peritoneal sclerosis (EPS) is a rare, life-threatening condition. It is characterised by a progressive, intra-abdominal inflammatory process resulting in fibrous tissue constricting viscera. We report the aetiology, management, and outcome of EPS in Belfast.

**Method:** All patients diagnosed with EPS in Belfast over the past 5 years are included. Presentation, aetiology, imaging, pathology, and outcome are reported.

**Results:** 7 patients were identified with EPS. 4 males, 3 females; mean age 53.6 years (range 33-69). Aetiology included peritoneal dialysis (3), radiation enteritis (1), peritoneal dialysis and radiation enteritis (1), tuberculosis, cirrhosis, and beta-blocker use (1), infected aortobifemoral graft (1). Of the 7 patients, 5 underwent surgery. Median pre-operative and post-operative hospital stay: 25 and 62 days respectively. 3 patients required total parenteral nutrition (TPN) pre-operatively, 3 patients post-operatively; with 4 of the 7 patients discharged on TPN, 5 out of 7 (71.4%) patients are alive at median follow-up of 24 months. There was no 30-day in-hospital mortality.

**Conclusions:** Patients often require nutritional support before and after surgery. Peritoneal dialysis is a major risk factor for developing EPS but other aetiologies should be considered. These patients are complex and best managed in a specialised unit with access to nutritional support.

**0183: PALLIATIVE STENTING FOR OBSTRUCTING COLONIC CANCERS**

A. Gungadeen, N.L. Wong, F.G. Bergin, J.M. Hanson, D.L. Richardson, J.Y. Graham, H.J. Gallagher. Newcastle upon Tyne Hospitals, Newcastle upon Tyne, UK

**Aims:** Stenting has been shown to be effective in relieving obstruction by colonic cancers. This study was designed to analyse the long-term survival of patients who underwent such stenting as a palliative measure.

**Methods:** Single-centre prospective data was collected from 2003 to 2011. Information about the procedure was obtained from patient case notes and only patients who underwent colonic stents as a palliative measure for obstructing cancers were included. Dates of death were retrieved from a national database, and post-stenting survival was calculated and analysed by age groups.

**Results:** A total 130 colonic stents were performed. 81 patients (31 female and 50 male, median age of 72) underwent palliative stenting. The median post-stent insertion survival was 7.6 months (range 0.1-68 months). 14 patients were alive at the time of the study. Older age groups and females had lower median survival in this study.

**Conclusions:** Colonic stents are associated with good long-term survival and are a good option to relieve malignant colonic obstruction. Older patients have lower survival rates post-stenting, probably owing to increased frailty and co-morbidities. It would be helpful to compare the survival of stented patients with those who undergo surgery to palliate acute obstruction.

**0225: EARLY STOMA CLOSURE FOLLOWING DEFUNCTIONING FOR LOW ANTERIOR RESECTION - A FEASIBILITY STUDY**

M. Elmasry, N. Eardley, M. Johnson, D. Vimalachandran, C. McFaul. The Countess of Chester Hospital, Chester, UK

**Aim:** To determine the feasibility of performing an early contrast enema, and then close the stoma as soon as possible without causing excessive morbidity/mortality.

**Methods:** Prospective 1 year study (June 2010-June 2011). All patients having a low anterior resection with defunctioning stoma had a contrast enema requested for 4 weeks following surgery, and if no leak was found, it was performed early. Primary end points: time to contrast enema, time to stoma closure, morbidity, mortality, delay in starting adjuvant chemotherapy. Secondary end point: radiological leak rate

**Results:** 15 patients were included. Median time from resection to contrast enema: 29 days. 5 patients were not suitable for early closure (3 because of a radiological leak). 10 patients underwent early closure. Median time from resection to closure: 46 days in those due to have adjuvant chemotherapy (n=4) and 67 days in those who did not need adjuvant chemotherapy (n=6). No morbidity/mortality following stoma closure.

**Conclusion:** We demonstrated a reduction in time to stoma closure with no short term morbidity/mortality. Costs of stoma care are estimated to be £3000 per year and so reducing time to stoma closure may result in significant financial savings (~£30000 in our small group).

**0228: CHARACTERISATION OF INDETERMINATE HEPATIC LESIONS IN COLORECTAL CANCER**

Shelly Griffiths, Irshad Shaikh, Emily Tam, Henk Wegstapel. Medway Maritime Hospital, Kent, UK

**Background:** Management of indeterminate hepatic nodules (IHN) in colorectal cancer (CRC) is challenging. Current NICE guidelines recommend referral to specialist units. We aimed to study whether certain patient and disease based factors can be used to give guidance with regards to further investigation, treatment and outcome of these lesions.

**Methods:** Data was collected via a 2-year retrospective case-note review of 539 patients discussed locally with a confirmed diagnosis of CRC and IHN on CT scan.

**Results:** 20 (3.7%) were found to have IHN. Of the 15 patients who had further imaging at the time of detection (US, MRI, PET), it was possible to determine the nature of 11 (73%) of these. Eight patients (40%) were later found to have malignant liver lesions (median follow-up 330 days). Malignancy was more likely with a larger nodule on initial detection and EMVI positive tumours, although significance was not reached (p<0.1).

**Conclusion:** This study demonstrates the difficulties of determining the nature of IHN using either patient or tumour characteristics. Significant factors appear to be a larger nodule at detection and EMVI positive tumours. Further studies are needed to elucidate any possible factors relating to the nature of these lesions.

**0235: ONE-STOP COLORECTAL CLINICS: IS THIS THE WAY FORWARD?**

Moustafa Mansour, Saadia Saqlain, Hannah Sayeed, Ruth Tipling, Khalid Canna. Inverclyde Royal Hospital, Greenock, Scotland, UK

**Aim:** It has been proven that earlier colorectal cancer detection is associated with better outcome. The aim of our study was to assess the outcome of our One-Stop Colorectal Clinic Service in terms of completion rates, incidence of positive findings and average number of visits from referral to diagnosis.

**Method:** Retrospective data of patients referred to our One-Stop Colorectal Clinic was collected from January 2010 to December 2010. A standard proforma sheet was generated including patient's age, reason for referral, procedure done, quality of bowel preparation, completion to caecum, findings and final outcome.

**Results:** 146 patients were reviewed. Caecal intubation was achieved in 127 patients (87%). 65 patients (45%) had no abnormality detected and were discharged after a single visit. 7 patients (5%) had colorectal cancer, 47 patients (33%) had benign polyps and further surveillance colonoscopy was arranged later according to pathology results.

**Conclusions:** One-Stop Colorectal Clinics are potentially efficient and effective in reducing the number of visits from referral to diagnosis. This was reduced to one visit for those with normal colonoscopies and two visits for those diagnosed with cancers. Fewer visits are associated with more convenience and lower costs. Savings can be used to improve other aspects of the colorectal service provided.